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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

V. 80, #1
JAN. 1965

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8 Pictures and Personal Sketches of 10 Outstanding Persons
Honored for their contributions to Medical Science.

Modern Medicine's 1965 Distinguished Achievement Awards

(see following pages)

To the men who make the great discoveries in medical science, to the men who apply them in practice, and to their teachers, Modern Medicine is privileged to say "well done" on behalf of the medical profession. The nominations for the Awards for Distinguished Achievement come from deans of medical schools, leaders of medical organizations, and members of the Modern Medicine editorial board. No honor has a merit higher than the merit of those who wear it, and this award has taken its luster from the names and achievements of the men who have won it over the years.

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The Health Bulletin

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Vol. 80 January, 1965 No. 1

**Ten
Outstanding
Physicians
and
Medical
Scientists
Honored
for
Contributions
to
Medical
Science**

Photographs and discussion
on following pages

Special recognition for their contributions to medical science was given this year to 10 outstanding physicians and medical scientists as the Editors of Modern Medicine announced their 1965 Distinguished Achievement Awards.

Nine men and one woman were selected from over 100 outstanding medical leaders nominated by deans of U. S. medical schools, leaders of professional medical organizations and members of the Modern Medicine editorial board. The announcement of the awards was made in the January 4 issue of the journal.

Initiated in 1934, the Modern Medicine annual awards honor those of the medical profession who make great and continuing discoveries in medicine. The 1965 winners join the 280 distinguished physicians and scientists who have received the awards during the past 30 years.

The 1965 winners are:

Leona Baumgartner, M.D., assistant administrator for technical cooperation and research, Agency for International Development, Washington, D. C., for her concern with the health of man manifested by contributions to public health as a scientist and administrator in an increasing sphere of influence.

Oscar Creech, Jr., M.D., professor of surgery and chairman of the department of surgery, Tulane University, New Orleans. Dr. Creech was cited for his development of regional perfusion in the treatment of malignant diseases and for the impact of his work on cardiovascular surgical techniques.

Derek E. Denny-Brown, M.D., professor of neurology, Harvard University, and director, neurological unit, Boston City Hospital. Dr. Denny-Brown was honored for his application of the accumulated knowledge in basic biological sciences to the elucidation of obscure neurological disorders, giving hope for their ultimate control.

A. Baird Hastings, Ph.D., professor of biological chemistry, emeritus, Harvard University, and head of the laboratory of metabolic research, Scripps Clinic and Research Foundation, La Jolla, California. Dr. Hastings received the award for his brilliant and imaginative discoveries in biochemistry, coupled with a practical approach to their clinical use, and for his influence as a gifted teacher.

Hudson Hoagland, Ph.D., executive director of the Worcester Foundation for Experimental Biology, Shrewsbury, Mass. He was selected for his organi-

zation of an outstanding biomedical research institution and for his work as a scientist and a humanitarian bearing on the world's problem of an exploding population.

Chester S. Keefer, M.D., professor of medicine, Boston University, Boston, was cited for broad talents as clinician, investigator, educator, and administrator that have significantly bettered medical teaching and practice.

William J. Kolff, M.D., head of the department of artificial organs, Cleveland Clinic, and professor of experimental medicine, Cleveland Clinic Educational Institute. Dr. Kolff was singled out for his development of practical methods for effective hemodialysis and for investigation and development of mechanical substitutes for essential biological structures.

Joseph L. Melnick, Ph.D., chairman of virology and epidemiology, Baylor University, Houston, was chosen for his work in basic virology especially with the enteroviruses, and the development of methods of stabilizing the poliomyelitis virus that enhance the safety of poliomyelitis vaccine.

John P. Merrill, M.D., director, cardiorenal section of Peter Bent Brigham Hospital, and associate clinical professor of medicine, Harvard University, Boston. Dr. Merrill was honored for pioneering in tissue transplantation and scientific studies of compatibility factors that have provided a biologically sound approach to kidney transplantation.

Francis D. Moore, M.D., professor of surgery, Harvard Medical School, and surgeon-in-chief, Peter Bent Brigham Hospital, Boston. He received the award for extensive work on the basic pathophysiology of the surgical patient that has widened the surgeon's scope, improved operative results, and promoted the patient's comfort.



LEONA BAUMGARTNER, M.D.

concern with the health of man manifested by contributions to public health as a scientist and administrator in an increasing sphere of influence

Assistant administrator for technical co-operation and research, Agency for International Development, Washington, D. C.



OSCAR CREECH, JR., M.D.

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and impact on cardiovascular surgical techniques

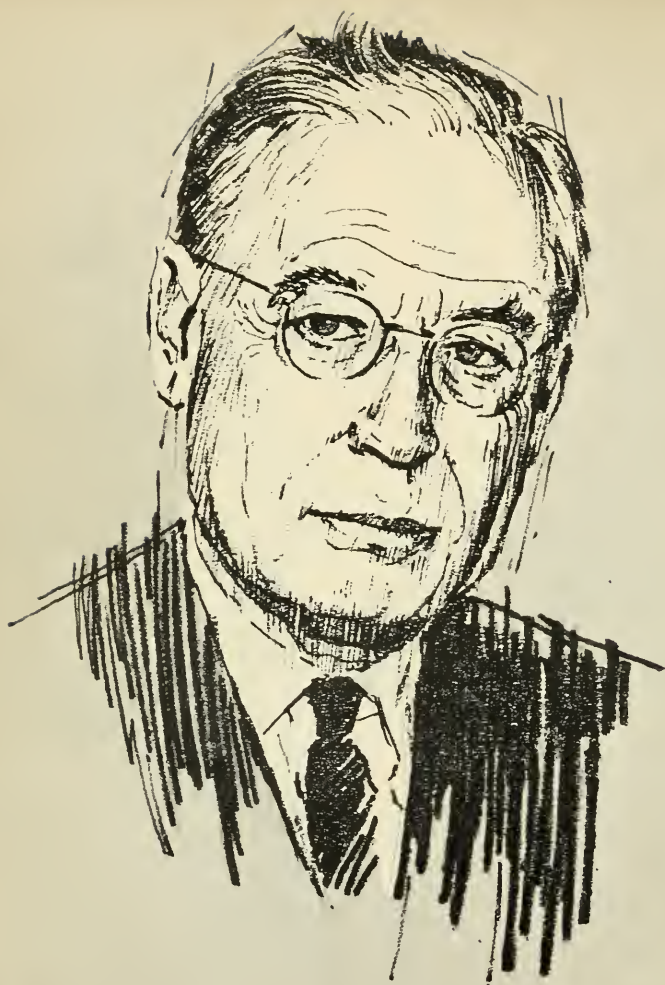
**William Henderson professor of surgery
and chairman of the department of sur-
gery, Tulane University, New Orleans.**



DEREK DENNY-BROWN, M.D.

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James Jackson Putnam professor of neurology, Harvard University, and director, neurological unit, Boston City Hospital.



A. BAIRD HASTINGS, Ph.D.

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Hamilton Kuhn professor of biological chemistry, emeritus, Harvard University, Boston, and head of the Laboratory of Metabolic Research, Scripps Clinic and Research Foundation, La Jolla, Calif.



HUDSON H. GLAND, Ph.D.

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Executive director, Worcester Foundation for Experimental Biology, Shrewsbury, Mass.



CHESTER S. KEEFER, M.D.

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Wade professor of medicine, Boston University.



WILLEM J. KOLFF, M.D.

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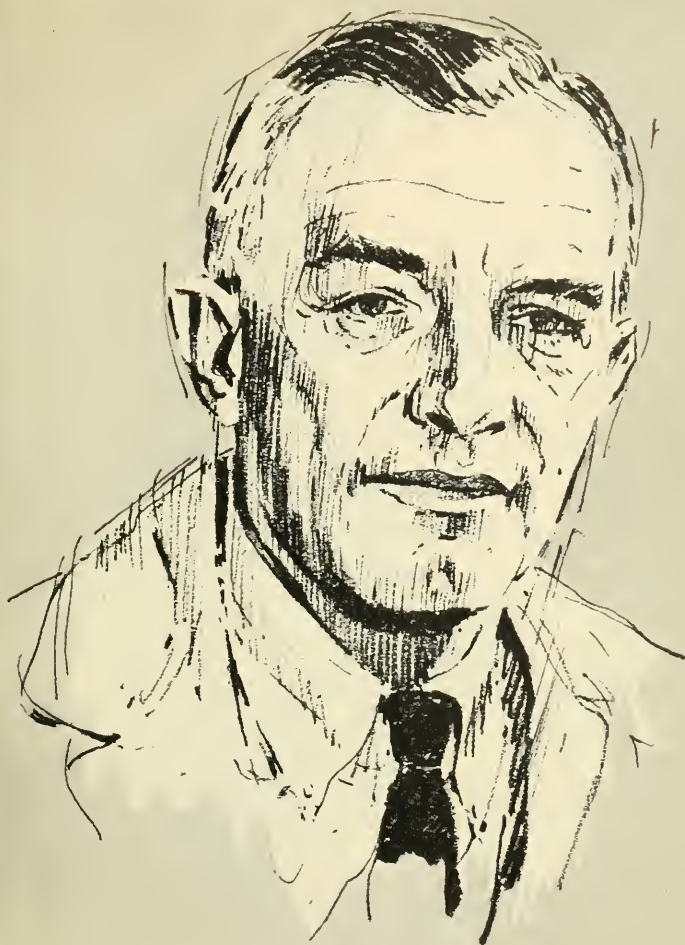
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JOSEPH L. MELNICK, Ph.D.

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Chairman, department of virology and
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ton.



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Director, cardiorenal section, Peter Bent Brigham Hospital, and associate clinical professor of medicine, Harvard University, Boston.



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Moseley professor of surgery, Harvard University, and surgeon-in-chief, Peter Bent Brigham Hospital, Boston.

Individual Air Conditioners Are Being Used

An individual air conditioner providing cool, clean air for workers exposed to heat is being used routinely on certain jobs in industrial plants in the southern United States.

The simple, low-cost device is described by W. F. Lienhard, M.D., San Diego, Calif., J. P. Hughes, M.D., Oakland, Calif., and T. A. Brassette, M. E., New Orleans, in the current (September) Archives of Environmental Health, published by the American Medical Association.

It could be particularly helpful for workers whose tolerance for heat has been reduced by aging, heart disease, or other physiological impairment.

Comparable observations on acclimatized workmen with and without the device during periods of identical work in a severely hot environment resulted in a threefold reduction in heat loss, a 25 per cent reduction in total heart beat, and a 50 per cent reduction in the rate of body temperature rise for

the air-conditioned man, according to the researchers.

The entire weight of the personal air-conditioner is only 19 ounces, according to the report. The air is cooled by a vortex tube, invented in 1931 by a French metallurgist, George Ranque. Standard industrial compressed air is delivered through a hose to the tube attached by a belt to the man's waist. The tube converts compressed air at 120 degrees Fahrenheit to a steady flow at 65 F.

Each worker has a "breakaway" coupling so he can detach himself from the air supply hose simply and quickly in case of danger. Hoses 150 feet in length provide the worker a high degree of mobility.

None of the earlier systems proposed for individual air conditioning has been widely adopted in industry because in general they have been too complex and too costly for day-to-day use on most jobs, the researchers commented. Vortex tube units with accessory equipment are commercially available. The vortex tube alone costs less than \$75.

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DATES AND EVENTS

- March 11-13—Annual Meeting, N. C. Mental Health Association, Hotel Sir Walter, Raleigh.
- March 14-17—American Mosquito Control Association, Tampa, Fla.
- March 14-20—National Poison Prevention Week
- March 19-21—American Society of Internal Medicine, Chicago, Ill.
- March 21-24—N. C. Association of Nursing Homes, Velvet Cloak Inn, Raleigh.
- March 22-26—American College of Physicians, Chicago, Ill.
- March 26-27—National Conference on Rural Health, Miami Beach, Fla.
- April 2-3 — Annual Meeting, N. C. Physical Therapy Association, Winston-Salem.
- April 4-9—American Industrial Health Conference, Bal Harbour, Maine.
- April 5-9—Southern Branch, APHA, Jung Hotel, New Orleans, La.
- April 7-9—National Council on Alcoholism, Tulsa, Okla.
- April 9-15—American Academy of General Practice, San Francisco, Calif.
- April 12-15—American Society for Public Administration, Kansas City, Mo.
- April 20-22—Eastern Branch, NCPHA,

Blockade Runner Hotel, Wrightsville, Beach.

- April 22-23—Annual Meeting, N. C. Tuberculosis Association, Robert E. Lee Hotel, Winston-Salem.
- April 22-24—Seventh Southern Regional Institute on Recreation with the Ill and Disabled, Chapel Hill.
- April 23-24—Annual Meeting, N. C. Chapter of the American College of Surgeons, Blockade Runner Hotel, Wrightsville Beach.
- April 23-24—Annual Meeting, N. C. Society of X-Ray Technicians, Asheville.
- April 25-28—Southeastern Psychiatric Association, Annual Meeting, Pine Needles Lodge, Southern Pines.
- April 27-29—N. C. PTA Convention, Jack Tar Hotel, Durham.
- April 25-May 1—National Library Week.
- April 28-May 1—American College Health Association, Miami Beach, Fla.
- April 29-30—President's Committee on Employment of the Handicapped, Washington, D. C.

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John Atkinson Ferrell, M.D., Dr.P.H.
December 14, 1880 — February 17, 1965

Feb. 1965

V. 80, #2

John A. Ferrell

The miraculous advance in a man's lifetime in public health in North Carolina and the world could be no better marked than by the service of Dr. John A. Ferrell who died here Wednesday night. He was, of course, as State Health Officer Dr. Roy Norton said, "one of the outstanding physicians of all time native to North Carolina." Perhaps the mark of his greatness was that in his quiet, useful, elder years here, as director of the State Medical Care Commission, many of the health dangers he confronted as a young man had all but disappeared.

He was only a young Duplin County practitioner in his twenties when in the first decade of this century he became assistant State Health officer concerned with combatting such plagues as typhoid fever and hookworm. Not everybody approved when, working with the Sanitary Commission and the Rockefeller Foundation, he extended his work in the campaign against hookworm. Some Southern patriots resented statements that much backwardness in the South resulted from this parasite which attacked so many rural people. Some considered the statements Yankee-financed slander. But understanding grew as health conditions improved. And Dr. Ferrell was called from the State by the Rockefeller Foundation to carry the work to the world.

That work would have been enough to place him in the company of the great physicians. But North Carolina was blessed when, as native after what might have been time for retirement, he returned to the State of his youth to help shape and direct Federal and State programs for hospital expansion in North Carolina. His was a long life filled with great service. He deserves remembrance as one of the truly eminent men produced by North Carolina in this century.

Editorial, Feb. 20, 1965, Raleigh New and Observer

Dr. Ferrell's Three Public Health Careers Come to an End

Dr. John A. Ferrell, public health pioneer, died late Wednesday night, February 17, at Rex Hospital in Raleigh. Funeral services were conducted at 11:30 a.m. on Friday, February 19, at the Church of the Good Shepherd. The Rev. James Beckwith and the Rev. Louis Melcher officiated, and burial was at 3:30 p.m. in Elmwood Cemetery in Charlotte.

John Atkinson Ferrell, physician and public health administrator, was born at Clinton, N. C., December 14, 1880, son of James Alexander and Cornelia (Murphy) Ferrell. His father (1832-1923) was a merchant-farmer; his mother was a daughter of Hanson Finla Murphy, M.D., of Pender County, N. C.

The family has been in North Carolina since colonial times, the earliest known representative of the line being Rev. James Alexander Ferrell, a Baptist clergyman of Orange County, N. C., in the eighteenth century. From him the descent is traced through Anderson (1804-43) and Mary (Dixon) Ferrell, parents of James A. Ferrell, 2d.

The maternal line also runs into colonial times, from Finla Murphy, who came from Arrau Island, Scotland, in 1747, through Hugh Murphy of New Hanover County, N. C., and his wife Catherine McMillan; through Cornelius and Catherine Murphy and Doctor Hanson Finla and Elizabeth Anne (Simpson) Murphy.

Dr. Ferrell was educated in the University of North Carolina, where he was graduated B.S., in 1902; and M.D., in 1907. Later, in 1919, Dr. Ferrell was graduated with the degree Dr. P.H. (Doctor of Public Health) by Johns Hopkins University School of Hygiene and Public Health, the first occasion on which this institution conferred this degree and he was the one and only graduate that year.

For three years, (1902-05), he was engaged in teaching and as superintendent of schools in Sampson County, N. C., and, during this time, entered upon the study of medicine.

He began practice in Kenansville, N. C., in 1907 and, in the same year, was made superintendent of health of Duplin County.

In 1909 John D. Rockefeller provided the funds for the control in the South of hookworm disease, which had been found so prevalent as to become a menace to the social and economic progress of that area. The Rockefeller Sanitary Commission was formed to carry out the purpose of the benefaction and Doctor Ferrell was chosen, early in 1910, to have direction of educational and control measures in North Carolina with the title of Assistant Secretary of the State Board of Health.

Although the disease, except among physicians, was little known, his pioneering efforts resulted, during the period 1910-1913, in educating the people throughout the State regarding the disease, its mode of spread and methods

for its prevention and cure, and in the microscopic examination of 320,872 persons, of whom 160,689 were found to be infected and were treated.

Upon the organization in 1913 of the International Health Board of the Rockefeller Foundation, to extend throughout the world such health work as had been conducted by the Rockefeller Sanitary Commission in the South and also to embrace activities in the whole field of public health, Dr. Ferrell was made Director for the United States. In this, he directed the work which involves the giving of financial aid and counsel to official health agencies for the development of essential branches of the State services and also the development of county organizations on a permanent basis. During his period of service, 331 full-time county organizations were established, toward 226 of which the Foundation contributed directly.

Dr. Ferrell, although active in the general field of public health, featured the strengthening of the State Health Departments and especially the establishment, development and extension of county health service.

In the United States, the Foundation provided aid for training of more than 200 medical health officers to occupy directive positions in the official health agencies (1919-27).

As Associate Director of International Health for the Rockefeller Foundation, Dr. Ferrell directed this Foundation's interests in the United States, Canada and Mexico until 1944. From 1944 to 1946, he served as Medical Director of the John and Mary R. Markle Foundation.

On October 1, 1946, he began a span of over ten years as Executive Secretary of the North Carolina Medical Care Commission. In this position, he directed the use of Hill-Burton funds in this State in the construction of 127 hospitals with an overall capacity of 6,567 beds, 41 nurses' residences, 3

diagnostic and treatment centers and 76 health centers—a total of 247 health projects involving an expenditure of \$95,931,033.

He retired February 1, 1957, and he and his wife had been living in Raleigh, North Carolina, since that time.

His activity in professional organizations is illustrated by his membership in the American Medical Association (Chairman, Public Health Service, 1922-23), the American Public Health Association (Member of Council 1926-29), the Southern Medical Association, the North Carolina State Medical Society (Secretary, 1911-13), the New Jersey State Medical Society, the National Malaria Committee (Chairman, 1924), and the Royal Society of Public Health.

The University of North Carolina gave to Dr. Ferrell its Distinguished Service Award.

He was the author of numerous

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 80 February, 1965 No. 2

papers and booklets on public health subjects, among which are: "Medical Inspection of Schools and School Children" (1912); "Malaria of the South" (1924); "Careers in Public Health" (1923); "Health in Relation to Citizenship" (1924); "Trend of Preventive Medicine" (1923); "The Public Health Nurse and County Health Service" (1926); "The County Health Organization in Relation to Maternity and Infancy Work and Its Permanency" (1927); "Survey of Provincial and State Health Organizations"—with aid of staff—(1927) etc.

Dr. Ferrell was married January 28, 1909 to Lucile Devereaux Withers, daughter of Benjamin F. Withers of Charlotte, N. C. They had one daughter, Bettie Devereaux, and two sons,

John Atkinson, Jr. and Benjamin Withers (deceased).

In tribute to Dr. Ferrell, Dr. J. W. R. Norton, State Health Director, said, "He was one of the outstanding physicians of all time native to North Carolina. His work here in early public health in the control of hookworm and typhoid set an example for the control of many other communicable diseases. His international service with the Rockefeller Foundation and his service with the John and Mary R. Markle Foundation made him uniquely qualified to direct the N. C. Medical Care Commission. In that responsibility he set a pattern for the ideal use of Hill-Burton funds in the development of the best hospital planning and health center construction to be found in the nation."

Death of Doctor Recalls Fight Hookworms Once Plagued Tar Heels

by Bob Brooks

Raleigh News and Observer

Only the oldtimers remember the campaign to stamp out hookworm disease in North Carolina.

It started in 1910, when a hardy bunch of pioneers in public health armed themselves with microscopes and began probing the "stools" of school children and adults over the state.

By slow train, buggy and horseback Dr. John A. Ferrell and his associates went into every county in a hookworm search that marked the beginning of active public health work in this State.

Real Giant

Dr. Ferrell's death here last month at 84 took from the State one of its real

giants in the public health field. His direction of the hookworm control campaign, as assistant secretary of the State Board of Health, may have been his most notable contribution.

It was a campaign which for the first time focused the Tar Heel public's attention on community-wide detection, cure and prevention of communicable diseases. Dr. Ferrell and his men conducted lectures on sanitation and personal hygiene wherever they went.

The hookworm, in the early years of this century, was a plague upon the rural South. The small worm attaches itself to the lining of the upper part of the small bowel and sucks blood from its victim. An infected person may have several thousand worms in him.

Rockefeller money helped in financing the State's effort to wipe out

hookworm disease. The work was directed through the Rockefeller Sanitary Commission. Dr. Ferrell was the commission's State director. He had six field directors.

Local governments were required to provide part of the cost. Their efforts at fighting hookworm on a matching fund basis led to the organization of local health departments.

In the beginning, there was something less than enthusiastic public acceptance of "the hookworm theory." Some of the newspapers in the State referred to hookworm infection as "the lazy disease" and "the fad."

Hookworm in the larval stage may enter the body through the thin skin between the fingers and toes.

Having been given this knowledge, some folks said Rockefeller was going into the shoe business and the hookworm campaign was a scheme to get southerners to wear shoes the year round.

The News and Observer commented that "many of us in the South are getting tired of being exploited by advertisements that exaggerate conditions."

But the press and the people rallied to the support of the campaign when the microscopes of Dr. Ferrell and his men began to produce evidence of what ailed a good many of the State's people. Carrying specimens in tin cans, the people stood in lines to await the attention of the microscopists. The infected ones got three doses of thymol and their health was soon restored.

The News and Observer said earlier skepticism about the hookworm campaign was not justified, and the paper joined in the effort to publicize the work.

Among Dr. Ferrell's field directors was Dr. Benjamin E. Washburn, who many years later wrote a lively account of the hookworm campaign in North

Carolina. His booklet was published in 1960 by the Rockefeller Foundation.

Dr. Washburn was one of the most successful field men in badgering appropriations out of county boards of commissioners. He travelled the rugged western end of the State. In the end, he and his colleagues squeezed money out of 99 of the 100 county governments. Only Ashe refused to cooperate.

"However, there were reactionaries," Dr. Washburn recalled. "At one place a member objected because he thought the money could better be expended in buying mules for the poorhouse farm. In another, in the county in which the State university is located, a member was shocked at the idea of paying a doctor to treat worms. He contended that a certain number of worms was necessary to aid digestive processes. . ."

Dr. Washburn recalled that while money was being discussed with the Alamance County Board of Commissioners, two doctors told of a case of hookworm they had treated.

Patient's Symptoms

Among the invalid patient's symptoms "was eating dirt, paper and chalk, and he was reported, as a youngster, to have eaten half of a Bible and an entire song book." After treatment, the book eater became a freight train fireman.

An "unfortunate incident" hampered the hookworm doctors work in Swain County. The doctor was giving his lecture at a church meeting before the preacher arrived. The preacher was delayed and sent word for the doctor to keep on talking. A woman in the audience dropped dead during the hookworm disease lecture.

"It may be that the lecture was too long," Dr. Washburn conceded.

Some of their findings baffled the hookworm crews. In Haywood County, they came upon a situation which surely would produce a shocking rate of infec-

(Continued on page 9)

Children Still Unprotected from Measles

With the advent of the 1965 measles season (February through April), Surgeon General Luther L. Terry, of the Public Health Service, Department of Health, Education, and Welfare, said recently, "only about 7 million children have been protected by measles vaccines, leaving about 20 million susceptible children unprotected.

"Measles is so common a childhood disease that 90 percent of our children get it before their fifteenth birthday. Nevertheless, it is not the harmless illness that most mothers seem to think it is," Dr. Terry warned.

Although recovery is routine for most children, about 500 children every year die from illnesses stemming from it. These are caused by encephalitis or pneumonia. About one out of every 1,000 cases is followed by encephalitis. Fifteen to 20 percent of the encephalitis cases are left with such after-effects as mental retardation, visual or hearing problems, or behavior disorders, and about 10 percent of the encephalitis cases die.

"Over 490,000 cases of measles were reported to the Public Health Service in 1964, and we suspect that only about one-tenth of the actual cases were reported," Dr. Terry said. Many cases are not even seen by a physician, he explained, because so many parents think of it as an "innocent" disease.

"Fortunately, effective vaccines are now available and vaccination can relieve the parents of worry about measles and its after-effects. Only a single dose is required. In the meantime, any child that develops the tell-tale red splotches should be seen by a physician at once," Dr. Terry urged.

Water Resources Curriculum to be Expanded

An expanded curriculum in Water Resources Development, to be inaugurated in the Fall of 1965 at the University of North Carolina, is to be offered jointly by the Department of Environmental Sciences and Engineering and the Department of City and Regional Planning. Engineers would generally enroll in the department while planners, economists and administrators would enroll in the Department of City and Regional Planning. In addition, the resources of the Institute of Government on this campus would be utilized.

Dr. Maynard M. Hufschmidt, currently Director of Research in the Harvard University Water Program, will be joining the faculty this summer to head this curriculum.

Ample funds are available for supporting graduate students in this program. If we can provide any additional information, please do not hesitate to write to Dr. Daniel A. Okun, Professor of Sanitary Engineering.

The dates for the North Carolina ANNUAL WASTE TREATMENT PLANT OPERATORS SCHOOL will be May 31 to June 4. The sponsors are: North Carolina Water Pollution Control Association, North Carolina State Board of Health, and the Institute of Government and the Department of Environmental Sciences and Engineering of the University of North Carolina at Chapel Hill. The School will be held in Chapel Hill. Persons desiring additional information may contact Professor George Barnes, Department of Environmental Sciences and Engineering, Chapel Hill, North Carolina 27515.

National Rural Health Conference Set for Miami Beach

Means of providing full-range health services for the nation's 60,000,000 rural residents will be discussed at the 18th National Conference on Rural Health March 26-27 in Miami Beach.

Among matters that will be discussed by farm and medical leaders will be implementation of programs for financing hospital and doctor costs among rural residents.

W. Wyan Washburn, M.D., Boiling Springs, N. C., chairman of the American Medical Association's Council on Rural Health, which is sponsoring the meeting, said the program was designed with four goals in mind:

- * To develop ways to utilize community health resources.

- * To improve methods of communication in health education for rural people.

- * To emphasize the responsibility of each family in promoting the health and fitness of its members.

- * To more fully understand the interdependence of rural and urban areas for the improvement of the health of the people.

The keynote address for the meeting will deal with "Health is a Way of Life." and will be delivered by Carl S. Winters, D.D., internationally known lecturer from Oak Park, Ill.

This will be followed by papers on "Preventive Dental Care," by Joseph Volker, D.D.S., vice president for health

affairs of the University of Alabama, and "Safe Use of Agricultural Chemicals," by Forrest E. Myers, of the Florida Agricultural Extension Service.

A feature of the March 26 afternoon session will be the panel discussion on "Practical Implementation of Health Care Programs." Participants will be Samuel P. Leinbach, M.D., Belmond, Iowa, the vice-chairman of the AMA council; Guithel L. Simpson, M.D., Greenville, Ky., chairman of the governor's Council on Indigent Medical Care; John L. Falls, M.D., Red Wing, Minn.; and John Allen, M.D., Madison, Wisc., director of medical services in the State Dept. of Public Welfare.

A series of elective discussion groups will follow. Topics will be "Improving Family Nutrition," "Communication to Improve Health Practices," and "Health of Migrant Workers."

Edward R. Annis, M.D., Miami, past president of the AMA, will speak at a banquet that evening.

The March 27 program will open with a play, "To Temper the Wind," which deals with homemaker services. This will be followed by a paper on "Medical Quackery," by J. Harvey Young, Ph.D., professor of history at Emory University, Atlanta, Ga., and a symposium, "Developing Community Health Resources."

Participants will be Dr. Washburn; Gertrude Humphreys, Morgantown, W. Va., a state home demonstration leader; Sewall Milliken, executive director, Public Health Federation, Cincinnati; J. Robert Anderson, Richmond, Va., director of the state's Bureau of Health Education; Peter Meek, executive director of the National Health Council, New York City; and Eugene G. Peek, Jr., M.D., Ocala, Fla., president of the Florida State Board of Health.

The summary speech, "The Challenge Ahead," will be given by Roy Battles, director, Clear Channel Broadcasting Service, Washington, D. C.

Robeson County

4-H'ers

Promote

"Slow Moving

Vehicle"

Signs as

Traffic Safety

Measure

by Selwyn B. Sampson

President of Pembroke's "Eager

Eight" 4-H Club

Mr. R. H. Livermore, President of Pates Supply Company in Pembroke, helps 4-H'ers start their campaign by buying signs to go on company tractors and other slow moving vehicles.

The triangular signs, with bright red center outlined in deeper red, show up equally well during night or day. They are designed for farm, highway and other vehicles that travel 25 miles per hour or less on highways.

Surveys show that many accidents involving slow moving vehicles are caused by the lack of adequate identification and that this often happens when visibility is poor or at night.

Club members are planning and working through the cooperation of Mr. Warren Mathers, safety co-ordinator with the Robeson County Health Department.

The purpose, need and value of the "slow moving vehicle" signs are being explained to all 4-H Home Demonstration and other civic clubs in an effort to create interest and desire among people of the county to the need to eliminate some accidents by properly identifying all slow moving vehicles, thus making our highways safer.

The 4-H tractor project is being carried by many of the county's farm youth who are learning proper maintenance and operation of farm tractors. Special emphasis has been placed on the importance of using these signs.

By providing literature, giving radio programs, writing news articles and selling safety tags for slow moving vehicles, many people of Robeson County are being made more safety conscious.

HOOKWORM CAMPAIGN

(Continued from page 6)

tion. A survey showed the county had few sanitary privies. Open-type privies were placed over the many streams and springs. The springs were the source of drinking water in many places.

Of the county's 15,436 population in 1910, 3,119 persons were examined and only 200 were found to be infected with hookworm.

The doctors didn't say so, but this seemed to be a high tribute to the rare qualities of Haywood's mountain air.

The Dental Care Program of Rowan County

A Dental Care Program for the Medically indigent, long felt as a need by the Rowan County Health Department, is now a reality as a result of the sum of \$10,500 bequeathed to the local health agency in the will of the late Judge R. Lee Wright of Salisbury.

Indeed, a dream has been fulfilled as well as a need. For with the original construction of the Health Center in 1953, a room for a dental clinic was included, which provided such basic essentials as water supply and sinks. However, for want of funds for dental equipment, the room has been used during the intervening years as extra office space. Now it boasts the finest of equipment.

"For use of the aged and infirm" were the terms of Judge Wright's will in designating his gift to the Health Department. As an appropriate use, the dental care program was selected jointly by Mrs. Sam Edwards, his niece, George R. Uzzell, trustee of his estate, and by the County Board of Commissioners.

The general objectives of the program are to relieve pain, to promote health, and to provide dentures for the medically indigent.

Specifically, and by established policy, the persons being served are the medically indigent residents of Rowan County of over age 65 who are not reached by other currently operating programs, such as the Kerr-Mills Bill. Under the latter's provisions, the Welfare Department can pay only for fillings, extractions, and denture repairs (for the medically indigent of over 65).

Particular attention is being concentrated for the time being on that segment of the eligible group who reside in any nursing, boarding, or rest home

financed by Rowan County taxes. To date, all patients served have come from the boarding homes.

The dental care is entirely free to the eligible. Incidental expenses are being met by the Chronic Disease Section of the North Carolina State Board of Health. No Rowan County funds are being used directly in the program.

The Rowan County Dental Society has actively supported the program and assisted with the selection of equipment. In addition they will continue as the source of the personnel to provide the service. At present Dr. Bruce A. Ketner attends the patients.

The clinic is in operation one half day a week, the current time being Wednesday mornings.

In expressing his gratitude for this addition to the Health Department's services, Dr. Moffitt K. Holler, Director, commented that, to his knowledge, this is the only dental program of its kind in North Carolina. Also he observed that the Rowan County agency is the only Health Department in the State to have received a bequest of money for a Health Department function.

"We are indeed appreciative of Judge Wright's kindness and generosity," said Dr. Holler. "And we feel that this program will be a fitting and lasting tribute to a fine gentleman, who was not only a leader in the civic,

(Continued on page 12)

(See Picture on Opposite Page)

FREE DENTAL CLINIC—The aged and infirm of Salisbury-Rowan are being afforded free dental service through the cooperation of the State Board of Health and funds left to the county by the late Judge R. Lee Wright. Dr. Bruce Ketner, currently conducting the weekly clinic, is shown with Mrs. Ben Blacklock, a patient at a local rest home.—(Post Staff Photo by Barringer).



DENTAL HEALTH

(Continued from page 10)

church, and professional activities of Salisbury, but who also rendered distinguished service to the entire County during his years in the North Carolina General Assembly and Senate and as Superior Court Judge of North Carolina."

Futilely, for some eleven years, the door of the clinic has borne the label "Dentist." Now at its entrance is a beautiful bronze tablet with the inscription:

This Room Equipped
in Memory of
Judge R. Lee Wright
and Wife
Sally Oakes Wright

The tablet was composed and placed in accordance with the suggestions of Mrs. Edwards, who had made her home with Judge and Mrs. Wright ever since the death of her own parents when she was four years old.

Poliomyelitis Vaccine Success Demonstrated

The success of the poliomyelitis vaccines is clearly demonstrated by three facts published recently by the Communicable Disease Center.

(1) Only 94 cases of paralytic poliomyelitis occurred in this country during 1964; this number is less than one fourth the number of paralytic cases reported during 1963, which was the previous record low year.

(2) No seasonal pattern of increased incidence was noted during 1964.

(3) There were no outbreaks of human poliomyelitis reported anywhere in the United States during 1964.

International Health

Meeting In Madrid

With the impulsive pressures of population growing every day in every part of the world, how can people concerned with health and health education effectively contribute to immediate and long-range action? This is one of the central questions being asked by leaders of the International Union for Health Education as they met in Paris recently to complete planning for the 6th International Conference on Health and Health Education, to be held in Madrid, Spain, July 10-17, 1965.

The theme of this world conference is "The health of the community and the dynamics of development." It combines concern with the various aspects of economic and social development with health and health education considerations. Also, it gives special attention to population problems and the migration into the urban cities—an "implosive" pressure in engineering terms.

A large group from the United States is expected to participate in the Madrid meetings, which will include technical study groups and tours of health and educational facilities as well as the usual plenary and related meetings. The program, reflecting the growing awareness everywhere of the importance of health as a primary factor in national growth, is characterized by originality and variety. It will combine the scientific with the practical in its approach to the problem of how best to create solid bases for effective action to ensure better health around the globe for all.

Write to the Editor of the Health Bulletin if you are interested in going.

Flim Flam Artists Are At Work

Two flim-flam artists were at work in Haywood County trying to conjure money out of households through a health ruse. According to Sheriff Jack Arrington, who issued the warning, the gimmick works like this:

Two white men—one about 45 and the other about 60—knock on a person's door and tell the householder that they are from the Haywood County Health Department.

The artists quickly explain that a new state law has been passed that requires each house to be sprayed inside for tuberculosis germs.

While one man is in the house spraying the rooms, the other man is outside cutting the telephone wires if there are any.

This gimmick has already worked in the White Oak Community, according to the sheriff.

He said an elderly man paid the pair \$140.00 to spray his house.

The sheriff's department learned about the incident after the man's son came home and found out what had happened.

So the sheriff has asked all persons to be on the look-out for the pair and should they show up, the sheriff would like for the owner to get as much information as possible—like color of their car, license number, description and such—and then refuse the service. After refusing the service, the sheriff said call his department or the nearest police department.

He warned that the flim-flam artists are "slick" enough to get by with talking some people into a spraying job.

People ought to only do business with people they know and then they would be safe," he added.

Short Course In Accident Control

The third annual short course in **Program Development in Public Health Accident Control** has been announced by the Department of Public Health Administration of the University of North Carolina School of Public Health. The course will be held at the School of Public Health in Chapel Hill, May 30 through June 4, 1965.

The course has been designed for:

- Administrators of state, city, or county health departments.
- Directors, supervisors, or consultants in nursing, sanitation, education, and other allied programs in state, city, and county health departments.
- Accident control workers in health departments.

Course content will include:

- Lectures on etiology, fact-finding, and program planning.
- Problem-solving by small multidisciplinary groups.

For further information, write to the Department of Administration, School of Public Health, University of North Carolina at Chapel Hill, or the Accident Prevention Section, North Carolina State Board of Health, Raleigh, North Carolina.

Herbert Shore, President of the American Association of Homes for the Aging, has announced that AAHA's Fourth Annual Meeting and Conference on "The Social Components of Care" will be held from Nov. 1-4, 1965 at the Disneyland Hotel, Anaheim, California.

Highlights of the meeting will include the presentation of the annual AAHA Award of Honor and a Legislative Breakfast Meeting on "The Aged in The Great Society".

UNC Professor Loaned to the Philippines

The World Health Organization (WHO) has selected a University of North Carolina professor as the public health nursing consultant for a National Seminar in Public Health Administration in the Philippines in February.

Dr. Margaret L. Shetland, director of the Public Health Nursing Teacher Preparation Program at the UNC School of Public Health and UNC School of Nursing, left in early January for her two-months assignment.

She will be one of three consultants for the seminar in Baguio, the summer capital of the Philippines. She will serve with Dr. F. Main of Northern Ireland and Dr. A. Yerby of New York City.

Dr. Shetland was chief nursing consultant with the U. S. Overseas Mission and visiting professor of public health nursing at the University of the Philippines in Manila from late 1956 to early

1959. This will be her first visit to the area since 1959.

The seminar in Baguio will be limited to provincial health officers in the Philippines, equivalent to state health officers in the U. S.

The seminar staff will devote a month to field visits and program preparation.

Seventh Recreational Institute

The University of North Carolina, through its Recreation Curriculum, announces that the Seventh Southern Regional Institute on Recreation with the III and Disabled will be held in Chapel Hill, North Carolina on April 22, 23, and 24, 1965.

The Steering Committee for this Institute met in Chapel Hill recently and formulated a very interesting, practical and progressive program. Detailed information regarding the Institute was sent out in January.

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Southern Branch, APHA To Meet In New Orleans

"Health Support in Man's Changing Environment," is the theme of the 33rd annual meeting of the Southern Branch, American Public Health Association, to be held in New Orleans, La., April 7, 8, 9.

Keynote speaker at the first general session will be Dwight F. Metzler, C.E., M.S., president of the American Public Health Association. Miss Elizabeth S. Holley, president of Southern Branch, will preside at the Wednesday and Friday sessions.

Speaking Thursday will be Dr. Paul Q. Peterson, Assistant Surgeon General, Department of Health, Education and Welfare, who will discuss "Social and Physical Environment." Dr. Leroy E. Burney, Vice President for Health Sciences, Temple University, will talk on "The Professional Environment: Scientific Knowledge, Technical Application and Fiscal Support." The third speaker will be Dr. Robert E. Coker, professor of

Dr. Murray Grant of Washington, D. C. visited North Carolina early in February speaking to a Seminar at the School of Public Health in Chapel Hill. He also spoke to the staff of the State Board of Health and is shown in the picture with Dr. J. W. R. Norton, State Health Director. Dr. Grant is Health Director of the District of Columbia which includes hospitals as well as other public health services in a budget of some \$50 million.

public health administration, University of North Carolina School of Public Health. His topic is "Organization for Support of Health." Dr. Russell E. Teague, state commissioner of health, Commonwealth of Kentucky, will preside Tuesday.

Summarizing the program at the branch meeting April 9 will be Dr. Malcolm U. Dantzler, director for the Charleston, S. C., county health department.

Program chairmen are Charles G. Jordan, engineering division, Dade County health department, Miami, Fla., and Dr. Robert F. Lewis, professor and head, division of biostatistics, Department of Tropical Medicine and Public Health, Tulane University, New Orleans, La.

Hosting the Southern Branch meeting will be the Louisiana Public Health Association, Inc., Miss Edna Irl Mewhinney, president.

Local arrangements committee chairmen announced prizes for pre-registration at the Jung Hotel, convention headquarters, and plans for a shrimp boil, 6:30 p.m., Tuesday, April 6. In addition, there will be Dixieland bands, sight-seeing tours, and other attractions to be found only in America's famed Mardi Gras city.



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DATES AND EVENTS

- March 21-24 — N. C. Association of Nursing Homes, Velvet Cloak Inn, Raleigh.
- March 22-26 — American College of Physicians, Chicago, Ill.
- March 26-27 — National Conference on Rural Health, Miami Beach, Fla.
- April 2-3 — Annual Meeting, N. C. Physical Therapy Association, Winston-Salem.
- April 4-9 — American Industrial Health Conference, Bal Harbour, Maine.
- April 5-9 — Southern Branch, APHA, Jung Hotel, New Orleans, La.
- April 7-9 — National Council on Alcoholism, Tulsa, Okla.
- April 9-15 — American Academy of General Practice, San Francisco, Cal.
- April 12-15 — American Society for Public Administration, Kansas City, Mo.
- April 20-22 — Eastern Branch, NCPHA, Blockade Runner Hotel, Wrightsville Beach.
- April 22-23 — Annual Meeting, N. C. Tuberculosis Association, Robert E. Lee Hotel, Winston-Salem.
- April 22-24 — Seventh Southern Regional Institute on Recreation with the Ill and Disabled, Chapel Hill.
- April 23-24 — Annual Meeting, N. C.

Chapter of the American College of Surgeons, Blockade Runner Hotel, Wrightsville Beach.

Charlotte's Occupational Health Conference, originally scheduled for March, has been postponed and tentatively set for October 7.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

March, 1965

V. 80, #3

Eldercare

Versus

Medicare

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**Some Comments and
Comparisons**

See page 2 and following

Medicare Awaits Senate Action

THE Medical Care of the Aged bill Congress is preparing for passage has a long, curious history.

Hospitalization-nursing home portions first were proposed about fifteen years ago. The idea had support from President Truman but failed to materialize.

Since then, the social security-financed plan consistently has been opposed by the American Medical Association and other professional and business groups. Until this session the bill never has been voted out of the House Ways and Means Committee. Thus, the House never has had an opportunity to act on it. The bill has now passed the House and is headed for several weeks debate in the Senate.

This year, however, the climate has changed dramatically. The AMA, even in the face of almost certain defeat, waged its strongest campaign against the administration's Medicare bill. And the AMA pushed its own answer to health care for the aged—Eldercare—maintaining that it offered far greater benefits than did Medicare. This was disputed by Rep. A. Sydney Herlong, Jr., (D., Fla.), co-sponsor of the Eldercare bill, who called AMA advertising "Misleading." For the AMA to give the impression the bill provides complete coverage is not so, he said. "It just makes it available for the states to provide it if they want to."

AMA's hard-hitting drive succeeded in part and perhaps not as the association intended. The campaign has succeeded, not in building opposition to Medicare as such, but in alerting the public to the fact that Medicare's benefits would be limited. Most letter writers to the House committee members said Medicare would not be enough.

Democrats on the House Ways and Means Committee realized that Medicare alone would be a disappointment to many elderly persons.

The committee decided to work out a comprehensive medical care bill for the aged to include payments for most drugs, medical devices, and physicians' fees. There would be some charge to prevent overuse of benefits, and an attempt would be made to work out a system for regaining part of the cost from wealthy elderly persons. The system would be voluntary.

So the AMA successfully focused public attention on Medicare's deficiencies but did not succeed in stopping the bill.

How the AMA-Supported Eldercare Bill Compares with the Administration Sponsored Medicare Proposal

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ELIGIBILITY

Eldercare Bill

Needy persons 65 and older. Partial or total underwriting of health care insurance determined by need limits set by states. AMA estimates 11,800,000 are eligible depending on need, not counting persons covered by such programs as Old Age Assistance (OAA) and Federal Employees Health Benefit Plan.

Administration Bill

All persons 65 and older, regardless of need. About 16 $\frac{2}{3}$ million eligible under social security or railroad retirement plans; about 2 million others to be covered through general tax funds.

CONTROL

Eldercare Bill

By state welfare or health agencies through existing Kerr-Mills channels after acceptance by state legislature.

Administration Bill

By Department of Health, Education, and Welfare through existing social security channels, allocations to be kept in separate Treasury trust fund.

COST

Eldercare Bill

Undetermined. One AMA estimate of nearly \$2 $\frac{1}{2}$ billion yearly is based on \$250 premium per person per year. Another AMA estimate is "between \$2 and \$4 billion."

Administration Bill

Estimated at \$2 to \$2.4 billion yearly.

FINANCING

Eldercare Bill

Through state and federal funds. Percentage of federal funds—52.5 to 84%—based on a state's per capita income, with lower income states getting a higher proportion. Funds are used by welfare or health departments to buy health insurance under guaranteed renewable private plans. Income levels to qualify for assistance would be determined by states, with the maximum at least as high as the highest level now required in the state under Kerr-Mills—presently ranging from \$1,080 to \$3,000 for individuals; \$1,560 to \$3,900 for couples. Persons above maximum would be ineligible for aid but could purchase the same noncancelable policies. Those between maximum and minimum would pay part of their premium on a sliding scale. Those below minimum would pay nothing.

Administration Bill

Through increased social security contributions. Total social security payroll deductions, including the portion for health care, from 1971 on, would be 10.4% (5.2% from employee; 5.2% from employer) or 7.8% for self-employed, deductions to be made on the first \$5,600 of salary rather than the current \$4,800. Payments are made to hospitals or other service providers or to Blue Cross-type organizations representing hospitals. Yearly outlay of some \$250 million is anticipated from general tax funds for those not covered by social security or railroad retirement.

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Vol. 80 March, 1965 No. 3

BENEFITS

It is impossible to compare benefits of the two bills since specific Eldercare coverage depends on each state. However, the Herlong-Curtis bill is a modification of the Kerr-Mills mechanism, so present Kerr-Mills practices are of interest, even though no state is committed to follow these practices as a basis for participation under Herlong-Curtis. Presently, 40 states, 3 territories, and the District of Columbia have operating Medical Assistance for the Aged (MAA) plans under Kerr-Mills. According to latest AMA figures (April 1964), 176,000 persons were receiving assistance.

HOSPITALIZATION BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

Sixty days per benefit period. Patient pays a deductible equal to the cost of one day national average hospital care. Recipient is entitled to this every 180 days if there is an interval of 90 days without hospitalization.

Kerr-Mills Experience. Of 44 states and territories offering hospitalization under existing Kerr-Mills program (AMA report, Dec. 23, 1964), duration of paid hospitalization varies from ten days per year (followed by review committee approval for possible extension) to no fixed limit. Nineteen states have no fixed limit but leave determination of duration to the administering agency. In 15 states with a fixed limit and no review mechanism, duration varies from twelve to seventy days per year. Nine states have a fixed limit with renewal for possible extension. Benefits in one state recently starting the program are unreported.

NURSING HOME BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

Sixty days per benefit period, no deductible. Recipients must be transferred from hospital to affiliated home or to one approved by HEW.

Kerr-Mills Experience. Of 30 states and territories offering nursing home care under existing Kerr-Mills program (AMA report, Dec. 23, 1964), duration of paid care ranges from twenty-six days per year to no fixed limit. Eighteen states have no fixed limit and leave determination of duration to the administering agency. Twelve limit the stay to twenty-six to one hundred eighty days per year. Only five states and territories require such care to be immediately preceded by hospitalization.

PHYSICIAN SERVICE BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

None. Private insurance carriers invited to provide such insurance without danger of antitrust involvement.

Kerr-Mills Experience. Of 39 states and territories offering physician payment under existing Kerr-Mills program (AMA report, Dec. 23, 1964), all have limitations. Some limit the number of calls per month or quarter, some have a ceiling on payment, and others limit the number of visits per hospitalization. Only 6 states limit physician payment to certain conditions, such as acute, chronic, or long-term illness. Four states do not pay physician fees under MAA mechanism but care for such patients without charge as staff patients.

DRUG BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

Covers cost of drugs customarily furnished when patients are in hospitals or nursing homes. No coverage outside these facilities.

Kerr-Mills Experience. Of 32 states and territories offering drug coverage under existing Kerr-Mills program (AMA report, Dec. 23, 1964), most are determined by the administering agency. Four states have a cost limit: \$120 a year, \$150 a year, \$15 a month, \$10 a prescription.

DENTAL CARE BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

None.

Kerr-Mills Experience. Of 26 states and territories offering dental care under existing Kerr-Mills program (AMA report, Dec. 23, 1964), 14 are restricted to certain dental conditions. One state has a \$100 limit. Another limits care to patients in hospitals or nursing homes. The rest leave determination of benefits to the administering agency.

OTHER BENEFITS

Eldercare Bill

Dependent on extent of insurance purchased by federal-state funds.

Administration Bill

Up to 240 nonphysician home health care service calls per year. Diagnostic outpatient services with deductible in any one month of an amount equal to half the average nationwide cost of one day's hospital care. Services of radiologists, pathologists, physiatrists, and anesthesiologists are included as hospital services.

Kerr-Mills Experience. Under existing Kerr-Mills program (AMA report, Dec. 23, 1964), such services as home nursing, outpatient laboratory work, or diagnostic X-ray are offered by 33 states.

Medicare Vs. Eldercare as viewed by Consumer Reports

AFTER two decades of effort, 1965 appears to be the year for Medicare—a Federally-administered national hospital insurance plan, financed through Social Security contributions for persons over 65. This time the administration's Medicare bill seems assured of passage. As usual, though, the American Medical Association has proposed a last-gasp substitute. A comparison of the two proposals is instructive.

The Medicare bill may of course be altered in the legislative process, but its four basic provisions are not likely to be changed significantly. They can be outlined briefly. For those over 65, Medicare would:

- Pay the full costs of up to 60 days of hospitalization (in ward or semi-private accommodations), minus a first-day deductible, for each benefit period (which begins on the first day of hospitalization and ends whenever the patient has accumulated 90 days out of the hospital within a period of 180 days).
- Provide for an additional 60 days of post-hospital care for each illness in a convalescent or rehabilitation center operating under an agreement with a hospital (not an ordinary, custodial-care nursing home).
- Pay for up to 240 home nursing visits a year under medical supervision, in programs organized by nonprofit voluntary or public agencies.
- Provide payment for hospital outpatient diagnostic services and tests, minus a deductible that would exclude routine low-cost laboratory or other diagnostic procedures.

These provisions would be financed by an increase in the Social Security withholding tax. Ultimately, a citizen would contribute (to a special, separate health care trust fund within the Social Security system) 0.45% of his earnings up to \$5600, and his employer would contribute an equal amount. Special provision would be made for those now over 65 who are not covered by Social Security through the Government's general fund.

The Medicare program gives the citizen free choice of physician and hospital. It does not pay the costs of doctor bills, out-of-hospital drugs, prolonged or catastrophic illness requiring long, continuous hospitalization, or extended custodial care in nursing homes.

CU's medical consultants believe that this is, by and large, a sound basic package. The 60-day provision would encompass all but about 5% of the usual hospital stays of older persons, and the extended-care proposal would both relieve the pressure on general hospital beds and spur the construction of badly-needed convalescent and rehabilitation facilities in many communities. Services of this kind are essential in many illnesses following their acute stage and prior to the time a patient can return to his home or transfer (if necessary) to a custodial institution.

The provision for organized home nursing services has obvious value: such services often preclude the need for hospitalization and permit earlier discharge from hospital or convalescent center. Out-patient diagnostic services also are capable of averting many costly hospitalizations by encouraging the early detection and treatment of disease—at a time when it may be cured or controlled by relatively simple short-term procedures.

Since the heaviest health cost of the elderly is hospitalization, the Medicare coverage could make it financially possible for the first time for many citizens to purchase voluntary insurance (of the Blue Shield type) to cover physicians' bills and other supplementary costs.

The AMA substitute for Medicare at first glance seems invitingly comprehensive. (It is, in fact, a resurrection of proposals made during the Eisenhower administration that the AMA bitterly opposed at the time, and again just a few months ago at its House of Delegates meeting. The AMA now refers to its "new" proposal as a "redefinition" of policy.) The AMA substitute simply proposes the use of state and Federal funds to buy Blue Cross-Blue Shield or commercial health insurance for indigent persons over 65—it does not say how the funds would be raised, in the absence of a Social Security tax.

The proposal does say, however, that a means test would be required to determine the eligible poor, with the states using state and Federal money to pay all, some, or none of the insurance premium cost, depending on the citizen's qualification under the means test. Means tests are—moral considerations aside—enormously expensive and difficult to administer. Furthermore, the program would be administered by the states, raising the possibility that there would be 50 different kinds of governmental machinery, eligibility standards, and payment procedures. (Under some state rules setting eligibility for help under the current Kerr-Mills law, ownership of property or even ability of one's children to pay can make an old person ineligible.)

The subsidized insurance would pay for physicians' and surgeons' bills and drug costs as well as hospital bills, and an AMA statement asserts that this would be "comprehensive health care" and not "limited to hospital and nursing home

care representing only a fraction of the cost of sickness." As CU has pointed out, however, this "fraction" covers the heaviest, the most financially crippling share of the burden. Furthermore, since the AMA has not spelled out specifically what the private insurance would cover (and in existing voluntary insurance policies, cash benefits, days of coverage, and other provisions vary widely from plan to plan and from area to area), it is difficult to tell how "comprehensive" the protection of the AMA's proposal would be.

The current Medicare proposal, obviously, will not solve every aspect of the nation's health problems, even for those over 65. It does not and cannot guarantee good medical care to its beneficiaries, and it pays relatively little attention to the quality of the services it pays for (though the bill does contain a provision for periodic review, by the medical staffs of participating hospitals, of the necessity for hospitalization, length of stay, and other such features). However, it is a significant beginning.

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Determining Medical Indigency

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BASIC in the provisions of Eldercare, sponsored by the American Medical Association, is the principle that the health care shall be made available only to persons qualifying as being medically indigent. Determination of medical indigency is admittedly a difficult and costly process.

The National Council on Aging presented a report on this subject at the 1964 meeting of the National Conference on Social Welfare. The report, entitled, "Principles and Criteria for Determining Medical Indigency", was published in full in the October, 1964 issue of the *American Journal of Public Health*.

The principles set forth in this report of the National Council on Aging are reprinted here on the following pages through the courtesy of the *American Journal of Public Health*, together with the comments of Milton I. Roemer, M.D., Professor of Public Health at the University of California, School of Public Health, in Los Angeles. Dr. Roemer was invited by the National Council on Aging to be one of the two discussants of this report at the National Council on Social Welfare and his comments carried in the March, 1965, issue of that publication.

These principles are goals that will not be attained quickly; in many instances they call for changes in legislation and policies and for training of personnel. Some changes could be made by revising administrative procedure and regulations. Others will depend upon the public's conviction of the need to expend the necessary funds.

The committee believes that carrying out the recommended principles will result in conservation of human resources and in prevention of suffering now caused when handicapping policies and unsound practices obtain in the determination of medical indigency.

Principles for the Determination of Medical Indigency

1. People who cannot afford medical care are entitled to it as a human right and as a sensible means of conserving human resources.

2. Neither race, creed, color, country of national origin, citizenship, nor length of residence should be criteria for determining medical indigency. Mental retardation, advanced age, or previous history of mental illness should not of themselves prejudice financial eligibility for needed medical care.

3. Determination of the amount and kind of medical care needed is a judgment of the health professions. The decision as to eligibility for aid in meeting this need should be a combined medical and social judgment, with due consideration given to implications of the illness or handicap for the family, estimated cost of care, relationship of the medical need to the patient's resources, medical or health needs of other members of the family, and special family needs.

4. Persons and families having incomes and resources at or below specified levels should be eligible for payment for medical care automatically.

Only for persons and families with incomes above the specified levels need further inquiry be made.

5. Criteria applied in determining financial eligibility should be objectively established and should not result in family insolvency.

6. Income levels for use in the determination of medical indigency should represent a reasonable level of living.

7. In order to provide for his medical care, no claim or lien should be taken on a patient's home and furnishings or on equipment essential for earning a living.

8. No arbitrary income ceiling should be set beyond which no patient can be judged medically indigent.

9. Legal or administrative policies specifying that relatives assume financial responsibility are undesirable, except in case of the patient's spouse or the parents of a dependent child.

10. Community health and welfare agencies that provide or subsidize medical and dental care should collaborate in developing general policies as a framework within which each determines medical indigency.

11. When several agencies are dealing with a patient who can partially pay for his medical care there should be joint agreement on the respective responsibilities and shares in the total patient funds available.

12. The agency that provides the subsidy for medical care should determine medical indigency.

13. General policies should be administered flexibly in relation to individual circumstances and problems.

14. Qualifying conditions of eligibility should conform to social values of dignity, privacy, confidentiality, individual responsibility, and family unity.

These should be taken into account both in regulations established and in processing applications.

15. A public agency or institution rendering or subsidizing medical care has the obligation to consider an application from any person within the group it serves and to take action on an appeal of the decision.

These principles are fundamental to good administration of the determination of medical indigency. Extraordinary situations may sometimes arise when one of the principles of a more practical nature will need flexible administration on an individual basis. Present-day experience indicates that such situations rarely occur.

Dr. Roemer's Letter to the Editor of the American Journal of Public Health

To the Editor:

The report of the National Council on Aging entitled "Principles and Criteria for Determining Medical Indigency" and published in the October, 1964, issue of the Journal calls for comment.

This important document was given its first public presentation at the National Conference on Social Welfare, assembled in Los Angeles on May 26, 1964. It happens that I was invited by the National Council on Aging to be one of the two discussants of the report, as it was presented by Mrs. Edith Alt. My remarks and those of the other discussant (Mr. Carel Mulder of the California State Department of Social Welfare), however, have not been published.

There are some very serious social policy implications to a formal crystallization of the whole concept of "medical indigency" that may be overlooked, while—with the best of intentions—one is trying to improve medical care for the poor. The fundamental question is "how should medical care for the poor be financed?" rather than "how should medical indigency be determined?" I tried to explore these conceptual problems in my commentary on the report, which was as follows:

There can be no doubt that this report on principles for determining medical indigency, produced by the National Council on the Aging and summarized so very well by Mrs. Alt, is a positive contribution to the tasks of administration of medical care in the United States today. A variety of governmental and voluntary programs must now make such determinations, and effectuation of the principles advocated in this report would surely facilitate proper medical care and protect human dignity more than has often been the reality in the past. The principles proposed on key issues like property liens, residency requirements, relative's responsibility, court commitments, and so forth, would move us significantly further along the path from tribalism to social responsibility.

Nevertheless, as I read through this fine report—exemplary in its careful workmanship and presentation—I became more and more unhappy about it. My disturbance was not for what it said, but for what it did not say. I am aware that the distinguished committee, representing as it did organizations of diverse sociopolitical philosophies, set itself a specific task, to define "criteria of medical indigency," from which it deliberately did not deviate. Yet it is the very posing of this task that I would like to comment on.

Perhaps, as the "Foreword" of the report states, the project was 25 years

overdue, but why was it undertaken just now? Surely it is not unrelated to the fact that in 1960 we acquired in the United States the first federal public assistance legislation in which the concept of "medical indigency" has been embodied as a statutory basis for aid. This emerged from a national debate on health insurance for all of the aged. Crippled children's programs, Veterans Administration medical services, and certain other programs, it is true, provide federal funds for specific beneficiaries who are, in fact, "medically indigent," and purely local or state funds have long been used for the "medically indigent" under the "general assistance" heading. But the Kerr-Mills program on Medical Assistance to the Aged was the first amendment to the basic structure of welfare services for the needy in which federal support for this concept became crystallized into law.

The MAA amendments, of course, apply only to persons past 65 years of age, but it is perfectly clear that certain groups would like to see the concept extended to all age levels, and indeed the NCOA Report specifically emphasizes this wider applicability. The basic premise, therefore, is that the total population may, for the purpose of financing medical care, be divided into several more or less distinct classes. Based on the recommendations in the report, these would be essentially as follows (excuse my backward numbering which has its reasons):

5. The fully indigent—persons who need financial assistance for their basic living needs, as well as for all their medical care, in order to survive.

4. The wholly medically indigent—persons of such low income that, while they can eke out a subsistence life with respect to food, clothing, and shelter, need financial assistance for the medical care of any illness, if it is to be of adequate quality.

3. The partially medically indigent—persons whose income and family responsibilities permit them to meet ordinary living requirements as well as the costs of minor illness, but who require financial assistance for the costlier medical care of serious or prolonged illness.

2. The insured self-reliant—persons whose income and responsibilities permit them to meet ordinary living requirements as well as the cost of minor illness, and who are protected by some form of medical care insurance which covers the costs of major or prolonged (but not too prolonged) illness.

1. The fully self-reliant — persons who, with or without insurance, can meet without assistance all their living costs as well as all costs of medical care for any illness, minor or major.

Even this subdivision of the American population into five classes, intricate as it may seem, is really an oversimplification. As social workers know, there are various subclasses of fully indigent under Class 5. Under the principal "medically indigent" groups, Classes 4 and 3, there are numerous shadings and subdivisions depending on the type of illness, the availability of organized medical facilities, the attributes of the family at the time and place, and so forth. Under Class 2, the combinations and ramifications of insurance coverage and benefits would lead to another dozen or so subclasses, if the scene were fully analyzed. And even under Class 1, the definition would have to lead to numerous subclasses, unless it were so strictly applied that only a handful of oil magnates or movie stars ended up in it.

Yet, this is the kind of demographic gymnastics that we are led to by the conceptual premises of this report on "medical indigency." There are two dimensions to medical indigency, as the reports brings out so well, (a) the person and (b) the medical requirements,

and the range of variability along both these dimensions is very long, indeed. It is hard enough to make a sound judgment along the first dimension, but to do it along the second, and then along both in combination—if this is done scientifically and objectively—is an enormous administrative task. I was particularly struck by the somewhat cavalier brevity of the report on the need for "information and adequate interpretation on . . . anticipated duration and estimated cost of medical care" for a patient. Prognosis is tough enough for the soundest clinician, and attaching price tags to it as well calls for the combined wisdom of a William Osler and a John M. Keynes.

Mrs. Alt cogently points out that 42 per cent of American families—with incomes in the \$3,000 to \$7,500 range—are vulnerable to medical indigency; she believes that "a majority of these (families) will fall at some time within the medically indigent group." I suspect that this is a conservative estimate, but the administrative task is to identify which individual families in this "majority" and which dates within this "time" yield an affirmative decision on medical indigency.

Small wonder that all these complexities and uncertainties about the implementation of the concept of medical indigency have led most industrialized nations of the world to give it up completely. In its place, they have substituted systems of social insurance for medical care and networks of public clinics and hospitals for virtually all who come to their doors. Almost all countries have done this for the total population with respect to the costliest element in health service—care in a general hospital—including most recently our Canadian neighbor to the north.

The objection to the "medical indigency" concept lies not only in its enormous administrative complexity—which must of course be translated into

the costs and time and efforts of skilled professional personnel. These efforts could be far better spent on social case-work and other positive services. More important are its implications for the kind of medical care that people would and do receive in a class-structured system. A class-categorization of people for entitlement to medical care—whether into five levels as implied by this report or into ten levels or into two levels—leads inevitably into class-levels of medical service. The evidence for this is around us everywhere—in the crowded public clinic compared with the private medical office, in the public ward surgery by the assistant resident versus the private room surgery by the board-certified specialist, in the dental extraction versus the root-canal therapy. This, of course, was certainly not the intention of the dedicated people who have produced the report that Mrs. Alt has summarized. But there is worldwide evidence that for reasons that are at once economic, political, and attitudinal this is where it leads us.

We have been moving forward in America with a democratization of medical care through the vast growth of health insurance. We still have a long way to go, but progress is being made every day. Here in California, there is serious talk of emerging from our 19th century county hospital system for the separate care of the poor. The Social Security Act pension system was a milestone in helping to achieve economic independence and dignity for nearly all aged persons, without a means test. I hope we do not now encourage a movement backward, along the path laid out by the Kerr-Mills amendment, into a legally frozen class-ridden pattern for an American's entitlement to general medical care.

Milton I. Roemer, M. D.

Professor of Public Health, University of California School of Public Health, Los Angeles, Calif.



IMMUNIZATIONS START AT HOME

Members of the Staff of the State Board of Health took their own medicine Monday morning when they lined up for needed immunizations as the State Board launched a 17 month State-wide program urging early immunization especially of the new-born and of pre-school age children. Shown in the picture is Mollie Murray, who operates the Snack Bar in the Cooper Memorial Health Building, receiving one of her shots from Mrs. Ruth L. Edwards, public health nurse of the Wake County Health Department. Looking on, from the left, are Dr. Jacob Koomen, Jr., Assistant State Health Director; Dr. Ronald H. Levine, field epidemiologist of the State Board; and Dr. William E. Bellamy, Jr., of the Wake County Medical Society.

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No Certainty In Eldercare

The problem of the elderly ill who can not afford adequate medical care has been with us for a long time, but the latest Louis Harris survey puts it in clear perspective: It is the number one domestic issue in the country today. More than 32 per cent of all American families have an elderly member in need of special medical attention, and less than half of them can afford it, the Harris survey found.

That helps explain President Johnson's determination to enact the Medicare plan that would provide **guaranteed** hospital care for the elderly under Social Security. It is the high cost of hospital services which overwhelms the meager financial resources of so many old people.

The Medicare plan is under attack by the American Medical Association which proposes an alternative it labels as the "Eldercare" plan. This alternative would, the association says, authorize medical and surgical payments as well as payments for hospital bills. It would indeed **authorize** a wide range of health care services. But it would **guarantee** very little.

Under Eldercare, it would be up to the states to put up matching funds and decide the level of medical care provided. This could be as little as one day in a hospital and one visit annually from a doctor.

Some state legislatures would enact a niggardly program because of dominant conservative control in state government. Many more, such as North Carolina, would do the same because they can afford no better. This is not the only grave fault of the Eldercare plan, but it is one of the bigger ones not even hinted at in the glowing AMA sales pitch.

In contrast, the elderly would know what they were getting under Medicare and they could depend on it: Sixty days of post-hospital care, 240 days of home-health visits, and out-patient diagnostic service every year.

Editorial in Raleigh (N. C.) News and Observer, March 2, 1965

If you do NOT wish to continue receiving The Health Bulletin, please check here and return this page to the address above. ☐

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DATES AND EVENTS

- April 20-22—Eastern Branch, NCPHA, Blockade Runner Hotel, Wrightsville, Beach.
- April 22-23—Annual Meeting, N. C. Tuberculosis Association, Robert E. Lee Hotel, Winston-Salem.
- April 22-24—Seventh Southern Regional Institute on Recreation with the Ill and Disabled, Chapel Hill.
- April 23-24—Annual Meeting, N. C. Chapter of the American College of Surgeons, Blockade Runner Hotel, Wrightsville Beach.
- April 23-24—Annual Meeting, N. C. Society of X-Ray Technicians, Asheville.
- April 25-28—Southeastern Psychiatric Association, Annual Meeting, Pine Needles Lodge, Southern Pines.
- April 27-29—N. C. PTA Convention, Jack Tar Hotel, Durham.
- April 28-May 1—American College Health Association, Miami Beach, Fla.
- April 29-30—President's Committee on Employment of the Handicapped, Washington, D. C.
- May 1-5—Medical Society of the State of N. C., Queen Charlotte Hotel, Charlotte.
- May 1-7—National Mental Health Week.

- May 2-8—N. C. Special Week on Aging.
- May 3-7—National League for Nursing (Biennial Convention), Civic Auditorium, San Francisco, Calif.
- May 4-5—Association of American Physicians, Atlantic City, N. J.
- May 5-6—Annual Meeting, N. C. Dietetic Association, Jack Tar Hotel, Durham.
- May 6-8—American Pediatric Society, Philadelphia, Penn.
- May 7—Annual Conference of N. C. Rural Safety Council, YMCA, Raleigh.
- May 9-15—National Hospital Week.
- May 10-12—American National Red Cross, Detroit, Mich.

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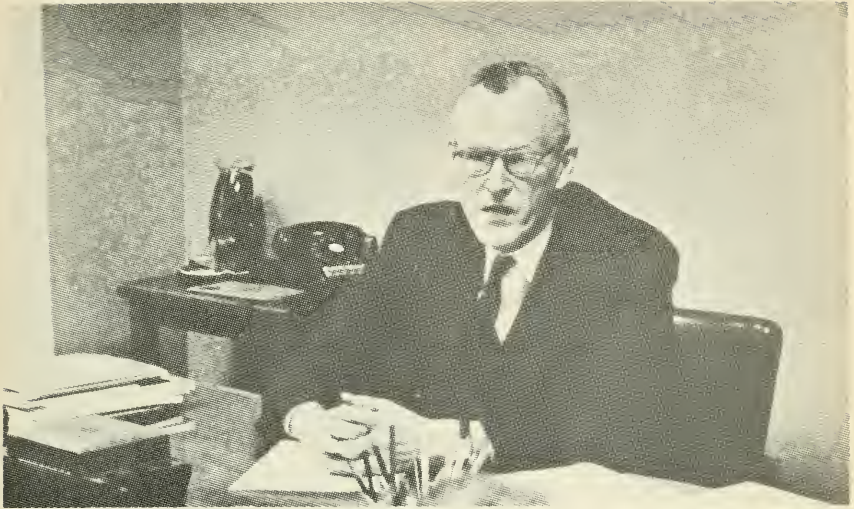
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A promising theory of modern cancer research holds that certain individuals (represented by the shaded fingerprints on our cover) share symptoms indicative of a high cancer risk. If this proves true, doctors will be able to identify, among a typical group like the one below, persons who are most likely to develop cancer and who therefore need more frequent and more specialized treatment. For more, see page 3.





"I have a theory that virtually all agents which can produce cancer, produce other types of changes first . . . The problem has been to launch an all-out search for such symptoms, which is just what we're doing in the cancer prevention study."
"In a fundamental sense, all health is one nowadays. The battle against cancer inevitably involves fresh insights into what it takes to live and be healthy in a shrinking and increasingly complex world. Evolution has not adapted us to many of the things we are introducing into our environment, tensions as well as drugs . . ."

A Visit With Cuyler Hammond

By JOHN E. PFEIFFER

We call on the head of the American Cancer Society's Statistical Research Station who tells how the disease is being studied with statistics, surveys and data processing.

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IN the last analysis, all medical progress can be traced to clinical findings, to the recognition of significant differences between people who come down with a particular disease and people who don't. A classical example is the 18th century "superstition" that

milkmaids were protected from smallpox by previous infections of a related but far milder disease, cowpox, a notion that led to the development of successful vaccines. Today, as in times past, advances continue to come from shrewd observations, which are often based on highly sophisticated methods of gathering data and making inferences.

Such methods are being used in the increasingly intensive fight against cancer, in many ways the most challenging medical problem of our times. For more than forty years, the leader in this fight has been the American Cancer Society, Inc., which, in addition to supporting laboratory and hospital research, has launched large-scale surveys designed to provide new knowledge about the causes and prevention of cancer—an activity directed by E. Cuyler Hammond, head of the Society's Statistical Research Station and an internationally noted master of the subtle art of evaluating facts.

A Yale graduate and former industrial health investigator at the National Institutes of Health, Hammond is most widely known for findings on smoking and health. But his interests extend beyond the problem of lung cancer, as I learned when I spoke with him recently in New York, where American Cancer Society headquarters are located.

Hammond is a quietly intense, lean-

faced man in his early 50's. He chooses his words carefully before responding to a question and then starts talking at a rapid rate, looking at you with sharp eyes and usually punctuating the end of his answers with a smile. Dedicated to the full-time job of analyzing ideas that can be expressed precisely and tested (he works most nights and every weekend), he approaches cancer problems from a broad point of view.

"The greatest achievement of the last hundred years," he told me, lighting up his pipe, "isn't the hydrogen bomb or space travel or more washing machines. These things and a good deal more are all by-products of a more basic development, the spectacular improvement in health which has given us time for longer periods of education and for longer productive lives. If you look back at the records for this country you can see that the big killers were, as they still are in some parts of the world, infectious and parasitic diseases such as malaria, smallpox and tuberculosis. The huge decline in death rates has been above all a result of preventive medicine, slum clearance and sanitation and vaccines and other public health measures.

"Our biggest problems today are heart disease, cancer and other degenerative illnesses which generally take years or decades to develop and tend to

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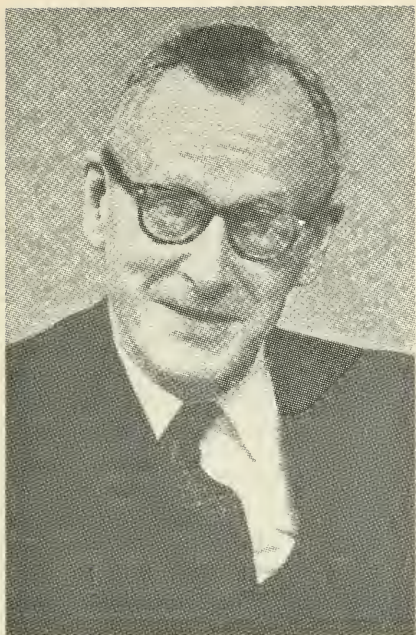
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"The past thirty years or so have seen a notable increase in cure rates, one major reason being the American Cancer Society's public education program."

strike later in life—and here again a central goal, together with improved treatments and cures, is prevention. As in the past, we must draw heavily on the techniques of epidemiology, the study of circumstances under which disease occurs in the human population. We want to discover critical causative factors, factors which increase the probability of sickness and death."

Accent on Statistics

Hammond is well aware of the difficulties of such research. For relatively minor ailments like athlete's foot, new treatments may be tested on patients without running serious risks. But when it comes to major diseases, investigators can't perform extensive experiments on human beings. Furthermore, animal experiments conducted under strictly

controlled laboratory conditions have only a limited, remote bearing on the uncontrolled and complex conditions of everyday life. So the accent is necessarily on statistics based upon observations rather than experiments. Since it is quite possible to draw invalid conclusions from valid facts, I asked about the pitfalls of the statistical approach.

"Let me give you an example," Hammond replied, as he paused to relight his pipe. "During World War II, I was stationed at the Air Force School of Aviation Medicine in Texas, and we were all very much concerned with the extremely high accident rate among pilots undergoing training. Some psychiatrists had the theory that most of the accidents were occurring among 'accident-prone' men, individuals psychologically predisposed to carelessness resulting in accidents. So, pilots recently involved in aircraft accidents were asked detailed questions about their childhood accidents—and they recalled a great many falls, broken bones and other mishaps. On the other hand, pilots who had never been involved in an aircraft accident reported very few childhood accidents. Apparently the accident-prone theory had been confirmed.

"I was immediately suspicious, however. For one thing, the results were too darned good. Hardly anything seemed to have happened during the childhoods of pilots with no training accidents, while everything seemed to have happened to less fortunate pilots. I suspected that there might have been some bias in response, because an aircraft accident can be a terribly shaking experience. A man may be in such a state of confusion and guilt afterwards that you could probably get him to 'confess' to beating his own mother. This is always one of the problems with the 'retrospective' or historic survey, that is, a survey involving people

who are already victims of the condition you are trying to learn about. Emotionally upset people cannot be counted on to give unbiased reports.

"So we decided to do a prospective or follow-up survey, questioning about twenty-five hundred consecutive pilots-to-be before they went into training. Then we put the records away in a safe. More than a year later, we went back and compared the records of pilots who had been in accidents during their first year of training and pilots who hadn't. As far as the number and severity of childhood mishaps were concerned, absolutely no significant difference existed between the two groups. In other words, it was useless to question applicants about their childhood accidents as a means of eliminating men most likely to be involved in an aircraft accident.

"This experience was very much on my mind 15 years ago, when we knew much less about smoking and cancer, and most of our statistics were based on retrospective surveys. But many of us, aware of the possibility of a bias factor and other problems, were frankly skeptical."

Hammond explained that the next step, as in the Air Force study, was an ambitious prospective survey—the first of its kind in this country and a task which only an institution like the American Cancer Society could undertake. In 1951, it mobilized more than 22,000 volunteers, many of them former cancer patients, to obtain complete information about the smoking habits of some 188,000 presumably healthy men between the ages of 50 and 70. In order to avoid possible bias on the part of the volunteers, the men were not interviewed; they were simply asked to fill out questionnaires. Having built up considerable good will among physicians and hospital authorities over the years, the Society had ready access to

medical details on those who died of cancer. When the time came for follow-up studies two years later, 11,870 men had died, 2,249 of them from cancer.

Analysis of the records confirmed retrospective studies in showing a definite association between cigarette smoking and cancer. "Just as important," says Hammond, "we had shown that follow-up studies were feasible on a very large scale, if you have a good organization behind you and plenty of volunteers. If we'd had to pay them what they were worth, it would have cost us several million dollars.

"Soon we began thinking about our ultimate objective: means of preventing many if not all types of cancer. In order to obtain information directed toward this goal, an even more extensive epidemiological study was required, one which would deal with other factors as well as smoking, other forms of cancer, and women as well as men. We worked out a most thorough questionnaire. Among other things it included occupation, details of present health status, education, eating and drinking habits, hours of sleep per night, and so on. The survey started more than five years ago, with 68,000 volunteers this time. The plan was to interview some million people aged 30 or older, and to follow up every one of them six times at annual intervals.

"Right now we're finishing our fifth follow-up and are beginning to analyze the data. We already have about three hundred bits of information about each person, so you can appreciate the magnitude of our task and why we've had to develop special ways of using electronic computers. In our work spectacular calculating speeds aren't nearly as important as effective man-machine communications. Since I like to plan as I go, what matters to me is how long it takes from the time I get an idea—a hunch, if you will—to the time I see an

actual printed table. Then I want to be able to modify my idea, or try another one in a reasonable time, and get a quick answer again. It's something like having a conversation with the computer."

What are the objectives of the current survey?

"Part of the story is indicated in the official name, 'Cancer Prevention Study.' The past thirty years or so have seen a notable increase in cure rates, one major reason being the American Cancer Society's public education program. The emphasis on danger signals, persisting symptoms such as hoarseness or unhealing sores which may result from early stages of the disease, has certainly helped alert people to the importance of prompt treatment. But we want to do better than that, to carry the offensive one step further.

"What we would like to do is discover complaints that appear before the disease process has a chance to establish itself. I have a theory that virtually all agents which can produce

cancer, produce other types of changes first. For example, lung cancer is always preceded by an appreciable increase in the number of cell layers in the bronchial tubes, more mucus and other effects which very probably develop years or decades before cancer. It also happens that such tissue changes within the body may be associated with symptoms like coughing and shortness of breath.

All-Out Search

"The problem has been to launch an all-out search for such symptoms, which is just what we're doing in the cancer prevention study. We are looking for signs on the broadest possible basis because, as things stand now, we don't know exactly where to look. We have asked our million persons how much exercise they get (none, slight, moderate, heavy), which of six medicines they use (never, seldom, often), whether they experience various degrees of some two dozen physical complaints, and a host of other questions. We hope to discover that certain of these factors,



"In a fundamental sense, all health is one nowadays. The battle against cancer inevitably involves fresh insights into what it takes to live and be healthy in a shrinking and increasingly complex world."

or "clusters of factors, may serve as warnings of impending cancers."

To Save More Lives

Nothing of this scope has ever been tried before, and Hammond pointed out that it is still much too early to predict just how the new approach will work out. But the American Cancer Society is conducting other important statistical studies, and he cited one of them as an example of future possibilities. A prospective or follow-up study is under way involving the occurrence of cervical cancer among more than eighty thousand women in Toledo, Ohio. The main purpose is to investigate a tentative finding which, if confirmed, might mean the saving of many lives.

"Earlier studies had suggested the existence in the population of a group of 'high-risk' women—women who reported any kind of cervical complaint such as discharge or bleeding. Remember that, as far as medical science can tell, they were absolutely free of cervical cancer. Yet follow-up observations indicate that they are 10-to-15 times more likely to contract the disease than women who did not have such complaints. Another important point is that they made up a small proportion of the total group, about one out of seven women.

"Now we're checking these results, among others, with the aid of an electronic computer and expect to have our answers within six months or so. Assuming that our preliminary findings are indeed valid, we shall make a strenuous effort to persuade these high-risk women to report for special medical examinations every six months. You can see the possibilities here. Most cervical cancer seems to occur in a group that can be identified beforehand, and the chances are good that by focusing on this group we may be able to lower death rates appreciably. Furthermore, our large-scale cancer prevention study

is designed to locate other high-risk groups, if they exist.

"This may also be the best way to get back to basic causes, a central aim of all our research. If high-risk groups are found and examined two or more times a year, medical investigators will have a unique opportunity to follow more closely than ever before the long and intricate process whose last stages are what we call cancer. According to one theory, the one I favor, this process depends ultimately on a special kind of genetic change.

"Think of the body's cells as populations of living things. They are continually dying and being replaced by newborn cells and, as in all populations, there are mutations or 'sports' in every new generation. Among the mutants some cells have the potential ability to multiply abnormally. They will not do so, however, unless conditions are right—that is, unless their environment inside the body is altered in a suitable way. For example, tobacco smoke may alter the environment so as to favor lung-cell mutants capable of malignant growth at the expense of normal tissue. A kind of natural selection may be working in the body, and our research will help us evaluate this theory and others."

Toward the end of our talk, Hammond emphasized the widening scope of the current large-scale survey. The primary purpose is naturally to cure and prevent cancer, but a prospective study by its very nature provides significant information about a variety of conditions. For example, out of the million persons originally interviewed five years ago about forty-five thousand have already died—and, as expected, a large proportion of them died from heart and circulatory diseases. So it is hardly surprising that results are of considerable interest to specialists in many fields.

"An enormous amount of data will have to be processed here, with implications for the social as well as the medical sciences. Many of our subjects have moved, and in tracing them and obtaining their records we are collecting material about the shift of people from country to city, about the effects of migration on health and the family. In other words, we shall have an incredibly large number of associations of significant relationships to explore. We receive requests for information from business schools, sociologists, psychologists and many other sources. But we have hardly scratched the surface as far as a full analysis of the data is concerned. That could take another decade, or another generation.

All Health Is One

"In a fundamental sense, all health is one nowadays. The battle against cancer inevitably involves fresh insights into what it takes to live and be healthy in a shrinking and increasingly complex world. Evolution has not adapted us to many of the things we are introducing into our environment, tensions as well as drugs and other chemicals. We must adjust culturally and a most important example of that is the continuing drive to prevent disease and raise health levels everywhere. This is the challenge which confronts us all, and if past successes are any indication, I believe we can look forward to significant progress in the future."

Research Being Done in Public Health Practices

Progress on organizing research into the evaluation of public health practices was reported at the annual meeting of the American Public Health Association last year by Dr. Vlado A. Getting. The paper presented by the Professor of Public Health Practice at the University of Michigan's School of Public Health was developed by members of the multidisciplinary research team which is conducting the study under a grant from the Public Health Service.

Presently-used methods of evaluation were declared to be of little value because many depended in large part on arbitrarily established standards or measurement of effort which is equated with accomplishment. Another criticism was that standards which might be suit-

able in one place or under one set of circumstances might not be in another.

The study at the University of Michigan was set up, Dr. Getting said, to work toward: "the development of tools for the evaluation of program effectiveness, the exploration of factors that motivate people to follow health recommendations, and the identification of factors that influence an organization's ability to make desirable program changes."

In further definition of the objectives of the study, Dr. Getting stated the evaluation methods which it sought to develop should: permit a true assessment of the extent to which objectives are attained; be in such form as to permit a self-evaluation by the

operating agency; be applicable to any public health program regardless of size or complexity; and reveal the probable source or location of program weaknesses where such exist.

"Such evaluation devices will permit different localities to use the same methodological approach to evaluate quite different health programs," Dr. Getting said. "Each locality can assess what it has achieved with respect to its own locally defined objectives and needs."

The task of the study group has been divided into three steps, Dr. Getting stated: describe programs in precise terms as to their objectives; measure actual accomplishment, bearing in mind the difficulty of measuring directly some of the qualities of an objective, and whether any improvement noted may be due to causes other than the program under consideration; validate measurement devices by use on existing programs.

To date, Dr. Getting indicated, the group's work has consisted mainly of "developing means of describing program objectives and activities in a manner that will permit subsequent evaluation." For this purpose a "Guide for Identification of Program Activities and Objectives" for use by program personnel of health agencies has been developed.

"In this guide," Dr. Getting said, "the work that constitutes the program to be evaluated must be locally defined. The instructions suggest only one caution: If a program is unusually large and complex, it may be better to subdivide it and treat the parts as individual programs." The agencies are asked to list program activities and their components, and the objectives of each activity. Definition of objectives is requested in "statements that are precise and complete enough to permit an accurate measurement of the extent to

which they are being accomplished."

According to Dr. Getting, the expression of program objective should meet these requirements: "The statement must refer to a need, situation or condition that is external to the person or agency conducting an activity . . . It must be stated with sufficient precision to indicate both quantitative and qualitative aspects of desired outcomes."

Dr. Getting said further that "it may be necessary to identify the validity of assumptions that underlie the use of particular activities to achieve particular objectives, and the assumptions that link together the several program objectives and sub-objectives."

There is a probability, Dr. Getting said, "other approaches to evaluation of public health practice, such as the expert survey technique, will be tested at some future time."

Several other studies were also mentioned. Among these were investigation of the most effective way of determining people's health beliefs and their actions to protect their health, and identification of key factors influencing health agencies to adapt to meet changing conditions and needs.

Summing up, Dr. Getting stated that "the program includes research on the program effectiveness and on the conditions under which health organizations are able to modify their programs and organization in the interest of increased effectiveness. Other research seeks to throw light on personal decision-making processes in health areas, and to develop a better understanding of how people are persuaded to change their health practices. The research program is beginning to produce experimental tools which will have to be field tested over a period of years but progress to date indicates that the results will be useful in the difficult but highly important task of strengthening community health practices."

Choose Your Own Color of Hair

attitude toward their use, says Today's Health, the magazine of the American Medical Association.

Today, hair color is not just acceptable—it is high fashion, says the magazine article, prepared by a noted dermatologist and a cosmetic chemist, in consultation with the Committee on Cutaneous Health and Cosmetics of the AMA.

This year Americans are expected to spend one hundred million dollars on hair-coloring products. While women are the principal users, many men also use hair color.

Hair color can be modified in one of two ways. The natural pigment of the hair can be bleached, and thereby lightened, or artificial coloring can be applied. Often both operations are carried out to produce the desired effect.

The importance of reading and observing the directions for using all hair-coloring products cannot be over-emphasized. This is especially true of the permanent colors. They are most difficult to remove. Modern hair-coloring products will give excellent results for most users, but only if the instructions are carefully followed.

One of the major causes of dissatisfaction by home users is the mistaken belief that a single application of hair color will produce any desired shade. This is not so. It is quite simple to cover gray hair or to color light hair a darker shade, but it is not yet possible for a single application of any hair coloring to change black or dark brown hair to a pale blond.

Peroxygen compounds, especially hydrogen peroxide, are widely used in bleaching hair. Six per cent hydrogen peroxide solution is the standard strength, and is safe, if proper precautions are observed. Stronger concentrations can produce burns and blistering of the scalp. Excessive bleaching can leave the hair harsh, strawlike and

The last few years have seen a flood of new hair-coloring products, and hand-in-hand came a change in public

brittle.

Largest and most important group of hair dyes are those based on synthetic organic chemicals. These are in three categories—oxidation dyes, semi-permanent dyes and temporary rinses. Oxidation dyes are the most widely used.

Most professional hair coloring or tinting is now done with oxidation dyes, and they also have become popular for home use. They are the only products that color the hair quickly and yet produce all varieties of natural hair shades which are lasting.

The biggest question about oxidation dyes is their hazard. It has been estimated that about one person in 50,000 will have an unpleasant reaction, such as a skin rash, swelling about the eyes, redness and crusting of the face and neck, plus itching and discomfort. The victim, while uncomfortable, should be aware that this is not a serious illness and that she will recover.

Included with each package, according to federal regulations, are instructions for performing a patch test before using oxidation dyes, to determine whether there is an allergy. The test should be repeated before each application of the dye. And the dyes should not be used on eyebrows or eyelashes, because of possible danger to the eye.

In addition to the oxidation dyes, there also are semi-permanent dyes, which usually will wash out with one shampoo; acid color rinses, using harmless organic acids; vegetable dyes, principally henna, and metallic dyes, no longer as popular as in the past.

If you decide to change the color of your hair, and if you decide to do it yourself rather than seek a professional job, the important thing to remember is to read the instructions on the label and the package insert, and follow them carefully. These are for your own safety and protection.

Film On Occupational Health Is Now Available

The Occupational Health Division of the U. S. Department of Health, Education and Welfare has made available to the State Board of Health a new motion picture, "The Hidden Hazards." This film is obtainable on loan from the Film Library of the State Board, Box 2091, Raleigh.

"The Hidden Hazards" tells the story of occupational health. It shows how man has progressed from the early trades with obvious dangers, today's complex operations, in which the hazards may be less evident. See what is being done to protect employed men and women from those health hazards which arise in the course of their work.

Starting on a dramatic note—the near fatal poisoning of a metal shop worker—the HIDDEN HAZARDS depicts the growth of occupational health. The film traces the change in attitudes and practices over the years. The apathy of ancient times, when slaves carried on the dangerous trades, has gradually been replaced by action to safeguard worker health.

Today everyone recognizes that certain kinds of work are more hazardous than others. Sometimes the danger comes from the conditions under which men work. Sometimes it lies in the materials they use. Often workers are surrounded by dangers they cannot see.

Occupational health presents a challenge of vital concern to all Americans.

It is our hope that this new 28½-minute, 16 mm, black-and-white, sound film will be widely used for showings before civic and fraternal organizations, women's clubs, and business and labor, as well as professional, groups. It may also be of interest to secondary school students from the standpoint of career opportunities.



HOPE FOR HEARTS—When the former Hope Cooke, newly crowned queen of the tiny Himalayan kingdom of Sikkim, recently visited her cousin, Mrs. R. Phillip Hanes of Winston-Salem, alert Heart Association volunteers posed Her Majesty with a "Hope for Hearts" poster. "Hope for Hearts" is the theme of the North Carolina 16th Annual Meeting and Scientific Sessions (Durham, May 20-21) which will feature special sessions for the general public and lay Heart Association Volunteers as well as for family physicians.

DIAL "H" FOR HEART — Five-year-old Sheila Dial, who recently underwent heart surgery at Duke University Medical Center, receives a surprise visit from North Carolina's Heart Mother of the Year, Mrs. Walter S. Cobb, herself a "graduate" of heart surgery. Mrs. Cobb is one of several hundred North Carolina Heart Association Volunteers who will be in Durham on May 20-21 for the State Heart Group's 16th Annual Meeting. Looking on, above right, is Mrs. Melvin Dial, young Sheila's mother.



Community Safety Courses Being Offered

Educational opportunities at both the graduate and continued education level in the field of community safety were announced recently by the Department of Public Health Administration, School of Public Health, University of North Carolina at Chapel Hill.

Expanding a program initiated three years ago, the department will enroll six graduate students in the curriculum leading to a Master of Public Health degree for the academic year beginning September 1965. Up to 30 students will be accepted for the short course dealing with program development techniques in accident control, which will be held May 31-June 4, 1965.

"The graduate program is open to

persons from the fields of education, nursing, engineering, social science, medicine, and allied fields of interest who are seeking careers as accident control specialists in a local, state, or national health agency or in a private organization," Dr. Charles Cameron, Professor and program director, said.

"Through a special grant from the U. S. Public Health Service, financial support is available for qualified students who are accepted in the master's program," stated Dr. Cameron. "Interested persons are urged to contact the department without delay."

Applications are now being accepted for the 1965 short course, according to Miss Janice Westaby, Assistant Professor and co-director of the program. Information can be obtained by writing to the Accident Control Program, Department of Public Health Administration, UNC School of Public Health, Drawer 229, Chapel Hill, North Carolina.

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Pesticides Are Dangerous — Follow the Directions

No matter how often you use a pesticide—for home, garden, or farm—or how well you think you know the directions, **READ THE LABEL** each time before you start work and **FOLLOW THE DIRECTIONS EXACTLY**. The other important rule is **KEEP PESTICIDES AWAY FROM CHILDREN**.

Other suggestions for safe and sensible use of pesticides are:

1. Use a pesticide only when you are sure it is needed and then use the one best suited to your needs. The label on the product explains the proper uses.
2. Keep pesticides in plainly labelled container, preferably the one in which it was bought. **Never** transfer pesticides to unlabelled or mislabelled containers.
3. Store pesticides under lock and key away from food items and **OUT OF THE REACH OF CHILDREN**, pets, and people who might not be able to understand their danger.
4. Avoid inhaling dust and fumes and avoid getting materials on the skin when handling, mixing, or applying pesticides.
5. If there is an accident, most pesticide labels advise washing the affected area with lots of fresh water in cases of external exposure. Check the label of the product **before using** so you know what to do quickly if there is an accident. Also, call a doctor or get the patient to a hospital immediately.
6. People who suspect special sensitivity to pesticides should consult an allergist and, if necessary, take

steps to avoid **any** exposure to the offending agent.

7. Wash hands thoroughly after using pesticides and before eating or smoking.
8. Get rid of used containers in a way that will not leave package or leftover contents as a hazard to people—particularly children—animals, or plants.
9. Work in well-ventilated area to avoid inhalation of fumes.
10. Do not spray into the wind.
11. Wear protective clothing, such as gloves, aprons, goggles, respirators, and masks, when so directed.
12. Change clothing after each day's operations and bathe thoroughly. If clothing or skin become contaminated, wash the skin and change to clean clothing. Wash contaminated clothes before reusing.
13. Avoid the fire hazard caused by smoking, defective wiring, and open flames when mixing or using inflammable chemicals.
14. In putting pesticides on food plants and crops, use the proper dose marked for the purpose and allow the full amount of time between applying and picking to avoid leaving a harmful amount of pesticides on food to be eaten.
15. Check sprayers before each use to make certain that hose connections are tight and valves do not leak.
16. Cover food and water containers when using pesticides around livestock or pet areas.
17. Do not spray or treat animals, their feeding areas, or plants with pesticides unless you are certain such treatment has been approved for that use.

... READ THE LABEL ... FOLLOW DIRECTIONS ... KEEP PESTICIDES AWAY FROM CHILDREN ...

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DATES AND EVENTS

May 20-21—Annual Meeting, NC Heart Association, Jack Tar Hotel, Durham. Speaker will be Dr. J. Willis Hurst, Atlanta, LBJ's heart specialist.
May 20-22—American Cleft Palate Association, New York, N. Y.
May 23-28—National Conference on Social Welfare, Convention Hall, Atlantic City, N. J.
May 24-26—Radiation Research Society, Philadelphia, Penn.
May 25-29—American Association on Mental Deficiency, Miami, Fla.
May 30-June 2—National Tuberculosis Association/American Thoracic Society/National Conference of Tuberculosis Workers, Chicago, Ill.
May 30-June 4—Third Annual Short Course in Public Health Accident Control, School of Public Health, Chapel Hill.
June 5-10—American Society of X-Ray Technicians, Chicago, Ill.
June 7-9—U. S. National Association of State Psychiatric Information Specialists, New York, N. Y.
June 9-11—Western Branch, NCPHA, Mayview Manor, Blowing Rock.
June 9-11—NC Hospital Association, Annual Meeting, Grove Park Inn, Asheville.

June 17-18—American Rheumatism Association, Philadelphia, Penn.
June 18-19—American Geriatrics Society, Americana Hotel, New York, N. Y.
June 20-24—Air Pollution Control Association, Toronto, Can.
June 20-24—American Medical Association, Annual Meeting, New York, N. Y.
June 20-24—National Association of Sanitarians, Annual Educational Conference, Miami Beach, Fla.
June 20-25—American Physical Therapy Association, Cleveland, Ohio.
June 20-25—American Society of Medical Technologists, Cincinnati, Ohio.

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1964 Handicapped American Welcomed in North Carolina

Jerry Walsh of New York City, 1964 Handicapped American of the Year, was recently in Raleigh promoting the work of the President's Committee on Employment of the Handicapped and the Arthritis Foundation. Mr. Walsh, who suffers from rheumatoid arthritis, was welcomed to Raleigh by Governor Dan K. Moore. Present with the governor were (L to R) Robert Pace of Chapel Hill, executive director of the Arthritis Foundation; Mrs. W. Kerr Scott of Haw River, honorary chairman of the Foundation; Mr. Walsh, the governor, Deborah Albright of Durham, Child of Hope for the Foundation; Mrs. Roy L. Albright, Deborah's mother, and Senator Irwin Belk of Charlotte, state fund raising chairman for the Foundation. Following the meeting with the governor, Mr. Walsh was welcomed to Raleigh by Mayor Pro-Tem W. L. McLaurin and presented the key to the City.

Dr. D. Frank Milam

Dr. D. Frank Milam, chief of the Cancer, Heart and Chronic Disease Sections of the N. C. State Board of



Health, died at his home in Chapel Hill on April 6, 1965. The Neurological and Sensory Disease Program of the state health department was one of Dr. Milam's major program interests since its inception approximately two years ago.

A native of Florida, Dr. Milam had a career in public health which spanned more than a quarter of a century and involved him in both research and practice at the state, national and international levels.

Beginning in 1924, Dr. Milam was a staff member of the Rockefeller Foundation and participated in pioneer studies dealing with human nutrition and related subjects. After 25 years in that organization, he became national director of the Planned Parenthood Federation for two years and later served as medical director of the New York Heart Association for nine years.

In 1959, he moved to North Carolina where he guided the development of program activities dealing with cancer control, heart disease activities, home care programs, and neurological and sensory diseases.

A spokesman for the Neurological and Sensory Disease Project Advisory Committee expressed grief at the loss and paid tribute to Dr. Milam's professional ability in guiding and developing the program in North Carolina.

Compliance With Civil Rights Act

In order to continue to receive federal funds, those organizations now receiving such funds through the state department of health must comply with the U. S. Department of Health, Education and Welfare regulations pertaining to title VI of the Civil Rights Act of 1964. In brief these provisions call for ". . . no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department. . . ."

In North Carolina, those organizations concerned have assured the North Carolina State Department of Health that they are complying with this act. These organizations have been contacted and the state department of health has received written assurance of compliance.

In a recent issue of Medical World News, a French veterinarian pointed out that tuberculosis among dogs and cats is rising. Approximately two percent of household dogs are infected with either human or bovine tuberculosis, and in some French cities the infection rate among cats is as high as 9 to 12 percent.

It is postulated that emergence of resistant tuberculous organisms are the basis for this rise in incidence among domestic animals. It is recommended that animals with tuberculosis be killed rather than treated in order to prevent the emergence of further resistant organisms.

Mobilization of Resources for Public Health Education

William C. Byrd, M. Ed., M.P.H.

The greatest problem facing the public health educator is the question of how to effectively reach the masses of people with the information and ideas that need to be conveyed. Further, the question of how to "educate" rather than merely transmit information, is an ever-present one. Many public health problems need education programs which result in new knowledge and modified attitudes and behavior. The mere transmission of information in no way guarantees these changes in attitudes and behavior.

Many times the health educator can reach the masses with information but cannot be sure how effective he has been. At other points he may effectively influence small groups of people and be able to measure his success, yet fall short of the goal of mass education.

We readily see that the success of a particular educational attempt depends largely upon the type of goal we wish to achieve, the availability of the audience and the means for reaching that audience.

Some fairly simple goals can be achieved with a substantial segment of our public by employing relatively simple techniques. This is witnessed by the favorable responses to fund raising appeals, mass immunization campaigns, community improvement programs and the like. The most difficult problem is to implement educational programs which effectively deal with ingrained attitudes and behavior. Family life education, alcohol education, mental health education and sex education are areas of public health interest that are very complex and are not effectively handled through the spot announcements, mass appeals or single film showings.

Too often, health educators have used such approaches as the "one night stand" and have assumed that the true goals were reached. But we often deceive ourselves and ignore some basic principles of education. It is quite possible for the health educator to occupy himself with innumerable film showings, talks, flip charts and flannel boards and be entirely confident of his worth, but still not necessarily accomplish any significant gains for the public health program.

To change attitudes and basic behavior, the educator must provide time for repetition and time for the audience to react intellectually and emotionally. It is difficult, if not impossible, to provide this time factor with the masses. Perhaps, if we had enough money, manpower and talent, a large part of our public could be reached effectively through television, but we do not have all of the necessary resources at our command.

Recognizing something of the size, complexity and nature of the total health education problem, we are appalled when we compare the task with the size of our force of experts who are assigned to do the job of public health

education.

What, then, can we do? First, we might well admit the fact that professional public health educators cannot possibly do the job alone. We must face the mathematics of manpower and realistically adjust our thinking and programming so as to reap the highest possible benefits from the limited investment we have to offer.

What does it mean to utilize the mathematics of manpower? For one thing, it means that we must establish wise and sound priorities for educational efforts. Once a public health problem is recognized, there follows the question of whether the problem can be ameliorated by way of education. Can the kind of education needed possibly be supplied with your present resources? Secondly, which audience should be the target of your immediate efforts, the actual problem group or some power group? A well-placed educational effort may be aimed directly at one relatively small group which, in turn, is in position to effectively influence or educate a larger body. In brief, our limited manpower should be invested in kinds of public health programs most likely to respond favorably and audiences who can contribute to the solution of selected health problems. Many varying factors will influence the priorities in individual communities and there is no standard plan

or method; however, some time and thought can be invested profitably in establishing priorities for educational efforts.

Again, the mathematics of manpower makes us ask this question: where and how can the health educator, the public health dentist, the nutritionist best invest his time and talent? Which is wiser, to use the health educator to do a series of talks on sex and V.D. education with high school students or spend the same time and talent teaching a group of high school teachers? Which is better, to have the dentist and hygienist give lectures to elementary school children or work with teachers as part of an in-service training program for the faculty? Which costs the public health budget the most manpower and which will result in the most health education? Who is better equipped to teach a third grade child, the dentist or the classroom teacher? The obvious answer is that the teacher is best equipped and situated. If she is not as well informed as necessary in dental health, then the dental hygienist, the health educator and the dentist can help upgrade this teacher's knowledge along with dozens of others at the same time.

These teachers, in turn, are ideally positioned to truly educate their students regarding dental health. In many instances, the wisest use of the public health educator's time is in thinking,

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studying the community and its health problems and serving as a liaison person and a coordinator. The health educator can be the needed catalyst who sees the problems more objectively and brings together the necessary talents and resources for solving the problem. Perhaps if health educators were doing more thinking and less "activities," we would accomplish more true education.

There are other useful questions for establishing priorities for educational efforts. How far will the investment go? How long will it last? How many people will it reach effectively? We have to guess at the answers, but an educated guess is helpful. Compare the ultimate usefulness of time spent with the local civic club as a speaker on the subject of alcoholism with the possible result of time spent with a group of interested clergymen, who have volunteered their time to study alcoholism.

A useful approach to public health education includes our looking around us to identify other persons who are in a position to help in this task of education, people who can be enlisted and "mobilized" to attack selected public health problems. Who are these

people who can and should be enlisted? First, they are people who, by virtue of their training, experience and present role are in a position of influence and in fairly frequent contact with a segment of our target population. At the top of the list is the public school teacher. At all grade levels the teacher has the opportunity to impart health knowledge and to develop helpful attitudes and behavior. The teacher has the distinct advantages of relative intimacy, prolonged exposure, an accepted position of leadership, and a professional background of educational training and experience. Again, the third grade teacher is infinitely better situated and better qualified to teach health to her students than is the public health dentist, nurse, hygienist or health educator. She speaks the language of the third grader, she knows her students as individuals, she can integrate health into the local classroom experience; she can relate it to art, language, number work, and the school lunch program. She can extend this interest and some of the activities over weeks or months, whereas, the public health personnel have very limited time to give to any one group. Ministers, law enforcement per-

At its recent Annual Meeting in Winston-Salem the N. C. Chapter of the American Physical Therapy Association honored Dr. Charles B. Kendall, Chief, Crippled Children's Section, N. C. State Board of Health. Dr. Kendall was cited for his distinguished work on behalf of the handicapped child in N. C. and for his long and continued support and recognition of the essential role of the physical therapist in planning for and meeting the health care needs of the citizens of this state. Presenting the award to Dr. Kendall is Miss Eleanor Flanagan, immediate past-President of the Chapter.



sonnel, selected health and welfare personnel, supervisors from businesses, industry and hospitals all are likely targets for special attention in health education projects.

Where, then, does the public health educator fit into this picture? The logical answer is for him to be the organizer, the coordinator, the planner. Too, it is up to him to know the abilities and limitations of various personnel who may be enlisted for health education purposes. He should be aware of the fact that public school teachers are, generally, less well prepared in health than in almost any other major subject area. He will realize his own limitations and know when to utilize the expert knowledge of other disciplines. He will be the one to realize and point out the practical limitations and the potentials of various educational approaches to health problems.

Are there concrete examples of health education projects that have really utilized the time and the talents of other groups to a substantial degree? Yes, there are many examples. For illustrative purposes, a few are briefly outlined below:

NO. 1 The director of the dental clinic in one city accumulated statistical evidence of the great need for dental treatment of young school children: about a third of the children at the third grade level needed treatment for periodontal problems, extractions and restorations. The percentage needing such treatment increased through the grades to more than fifty-five per cent needing treatment in grade nine. In the lower grades, it was found, only about half of the children owned a toothbrush. The question: what can be done educationally to help improve this situation?

The clinic director and health educator studied the problem and discussed

various possibilities. Finally, the educator and public health dentist went to the superintendent of schools and explained the problem, expressed their concern and enlisted his interest and promise of cooperation.

After further study, it was decided that the initial effort would have to be limited to one grade level; teachers would receive special in-service training on dental health, members of the Dental Society would assist in teaching the teachers and in visiting classrooms of the selected grade level. A manufacturer of dental health products agreed to furnish toothbrushes and selected teaching aids.

Within three months of the first discussion with the superintendent, the first of two seminars was held for about one hundred teachers of third grade. In these seminars the health educator, public health dentist and dentists from private practice presented basic instruction about tooth structure, the decay process, nutrition, proper toothbrushing and the importance of professional dental care. Printed guides, posters and films were used. These teachers then taught dental health units in their classrooms, utilizing these materials, free toothbrushes, and materials for simple classroom demonstrations.

Dentists from private practice visited the classroom involved (about one hundred) and did simple dental inspections. Previous to this cooperative program, the public health dentist had this responsibility, but with private dentists assisting in this manner, the public health dentist was free to spend more time in his clinic rendering services to indigents.

In the following years, similar seminars and programs were carried out for fifth grade level, second grade and fourth grade. The free toothbrush kit was finally used in only one grade per year, either second, third or fourth. The

expense and psychological impact were considerations. Each child would be reached with this kit in one of these three grades and would be getting appropriate dental health education through the fifth grade. Obvious results were seen in improved eating in the lunchroom, better choice of snacks for recess time, better awareness on the part of parents and better cooperation with the dentists, both in private practice and in the health department clinic. Also, a measurable improvement in dental health was observed in students who were exposed to the program from third grade through the fifth. While the clinical evidence was not dramatic, there were five per cent fewer children in need of professional care in this group as compared with previous groups of children at the same level. Also, there was reason to believe that overall nutrition was improved.

NO. 2 One health department surveyed the "Status of Health Instruction" in ninth grade health classes. In cooperation with the superintendents of the two school systems, the health educator and appropriate school supervisors visited all schools, noting facilities, class size, class location, etc. A questionnaire was sent to all teachers of ninth grade health; information was requested regarding major and minor areas of preparation, areas of health instruction in which teachers felt less well prepared; adequacy of textbooks, etc.

The study showed that teachers realized a need for more current and thorough knowledge of such matters as sex education, venereal disease education, community health resources, alcohol education, cigarette smoking and lung cancer, mental health and problems associated with adolescence and boy-girl relations.

The health department obtained a grant to finance a graduate level course

in "Modern Health Problems: The Teenage Population." Teachers were given tuition scholarships and earned three semester hours of graduate credit. In this course, they explored several areas of interest such as the teenager, the community, changing mores, incidence of venereal disease, illegitimate births, dropouts, alcoholism, and teenage marriage. They visited agencies and studied their services. Some thirty teachers carried this new knowledge into their classrooms to reach hundreds of youngsters that same school year. Each year, public health draws an interest on that initial investment as long as these teachers continue in their profession. Subsequent credit courses were offered in alcohol education and mental health; the original course was repeated with a new group.

NO. 3 An official agency for alcoholism education planned with a group of ministers for a series of some twenty-four half-day sessions to study and discuss alcohol and alcoholism. This group enlisted the aid of local psychiatrists, psychologists, social workers and a hospital chaplain to study the dynamics of the alcoholic personality, counselling the alcoholic and his family, referral procedures, and alcohol education. The health educator with this agency was the person who created the interest, worked with the various participants, and followed through after the series was finished.

NO. 4 An industrial education center sponsored "Human Relations in Supervision," a course adaptable to supervisory personnel from hospitals, industry or business offices. This course dealt with basic elements of positive human relations, problem-solving techniques and ways to avoid human relations problems.

Problem situations were brought to

(Continued on page 10)

Noise

Your Enemy

By Hazel L. Byrd
Industrial Hygiene Engineer
N. C. State Board of Health

YES, noise is damaging the hearing ability of thousands of people every day. This damage may be temporary or permanent depending upon the severity and duration of the noise exposure to the individual. Permanent noise induced hearing loss is due to destruction of certain inner ear structures which cannot be replaced or repaired. Absence of pain, when exposed to noise, should

not be accepted as absence of hearing loss. More often than not, the person who is "losing his hearing" due to excessive noise is not aware of it.

"What did you say?", shouts the retired riveter to his friend three feet away while walking through the park during the early morning hours.

NOISE, WHAT IS IT? A simple, direct definition: undesired sound.

SOUND can be measured with proper instruments. The term of measurement is "decibel" or "db". Using this arbitrary unit, "0" decibel would represent the sound pressure level of the weakest sound that could be heard by a person with superior hearing ability in an extremely quiet location.

Sound travels in waves similar to the ripples produced by throwing a pebble in a still lake. Sound pressure means the actual pressure exerted by the sound wave. Frequency means the rapidity with which the pressure alternates, measured in cycles per second.

Decibels, because of their logarithmic heritage do not behave normally when added together. Thus, when 60 db are added to 60 db, the result is 63 db, not 120 db. Doubling the sound power results in a 3 db increase in sound pressure level.

EFFECTS OF EXCESSIVE NOISE EXPOSURE:

1. Interferes with or makes impossible normal voice communications.
2. Contributes to accidents.
3. Causes loss of production.
4. May cause uneasiness, headache, blurring of vision, tremors, nausea, tenseness and dizziness.
5. May cause temporary or permanent hearing loss. Once a noise-induced hearing loss has been acquired, normal hearing cannot be restored.

NOISE DANGER SIGNAL should be recognized when the noise exposure

is habitual, and the noise is continuous during the working day (5 or more hours), and the average of the levels at 300-600, 600-1200, and 1200-2400 cycles per second exceed 85 db. Other considerations govern when the noise exceeds 85 db for more or less than 5 hours per day. Noise exposure (5 hours per day or more) of 90 db will adversely affect the efficiency of the individual. Intermittent exposures of 118-123 db will cause physical discomfort while 140-145 db will generate pain.

NOISE EXPOSURE CAN BE CONTROLLED by one or more of the following methods:

1. Environmental control
 - a. Reduction in amount of noise at the source.
 - b. Reduction in amount of noise transmitted through the air or building structure.
 - c. Revision of operational procedures.
2. Use of personal protection.
 - a. Ear plugs.
 - b. Ear muffs.

The choice of plugs or muffs or both depends in part on the work situation. Each has advantages and disadvantages. Before a choice is made between the two, all the circumstances of a particular job should be considered. Plugs should be fitted individually for each ear. If the ear canals are not the same size or shape, they may require plugs of different size. Dry cotton in the ear affords no or little protection from noise.

The pamphlet, "Guide for Conservation of Hearing in Noise", American Academy of Ophthalmology and Otolaryngology, is highly recommended for anyone interested in this subject. This pamphlet may be obtained free upon request to the Research Center of the Subcommittee on Noise, 327 South Alvarado Street, Los Angeles, California 90057.

TYPICAL OVERALL SOUND LEVELS:

General

(Distance from source of noise shown in parenthesis)

50 HP siren (100')	138 db
F-84 at take off (80' from tail)	133 db
Large pneumatic riveter (4')	130 db
Pneumatic chipper (5')	124 db
Trumpet auto horn (4')	115 db
Cut off saw (2')	114 db
Subway train (20')	95 db
Heavy trucks (20')	93 db
10 HP outboard motor (50')	86 db
Automobile (20')	75 db
Conversational speech (3')	63 db
Machines in industrial plants (Distance from machine 3' to 5')	

Textiles

Reducing machine (72 spindle)	93 db
Twister, cap type	91 db
Spinning frame	86 db
Card	86 db

Lumber & Wood Products

Wood Planer	108 db
Drum sander on veneer sheets	98 db
Jointer, 16" on millwork	96 db

Stone Carving & Cutting

Cutting large stone, 72" saw	97 db
Carving stone, pneumatic chisel	93 db
Cutting stone, 14" saw	90 db

Fabricated Metal Products

Cutting machine on hardened tools	113 db
Friction saw, 46", on 4" x 1/4" steel	107 db
Furnace, non-ferrous	105 db
Punch press, 25 ton, 3/8" brass work	101 db
Pneumatic vibrator, foundry	100 db
Boring machine	96 db
Tumbler, small castings, foundry	97 db
Sand muller, 1500 lbs., foundry	96 db
Shaper, small steel parts	95 db

(Continued from page 7)

the class, analyzed and discussed. While most of the course was elementary and at the laymen's level, many of the students declared that the study helped them with immediate problems and gave them a more positive attitude toward human relations with their employees. This type of study has strong implications for mental health and is also worthwhile to employers from the monetary point of view. The person who taught the course was a public health educator with some interest in mental health and with training in supervision.

Situations similar to those cited above occur in many communities and involve many disciplines. Their value cannot be measured with great accuracy, but the fact that they are valuable is attested to by the participants and clues are seen and heard for months and years afterwards. They represent fairly minimal investments of time and energy on the part of the so-called "expert" workers and offer the promise of long-term positive results, not with great masses of people, but with large groups of people who are strategically located and who, in turn, will be able to influence and help untold dozens or hundreds through their daily routine.

The approaches above represent an awareness of the need to enlist hundreds of key people to work for better health. There is reflected a realization that we all can teach to one degree or another and that people, at all levels, have opportunities to contribute to a better understanding of life and a greater appreciation of his fellowman. This is the "mobilization of resources" which can make a substantial contribution to health through education.

Similar undertakings have been carried out with nurses, social workers,

PTA unit health chairmen, parents and others. The strategy is the same: help others who can, in turn, help many others.

There will never be enough professionally trained health educators, social workers, psychiatrists, psychologists, or guidance counsellors. Our greatest hope is to invest a substantial share of our more expert manpower in the mobilization of community resources for health education. To accomplish this, we must enlist the official aid and cooperation of agencies as well as individuals. No one agency has either the manpower or the brainpower to accurately diagnose the community's health needs or to carry out programs broad enough to meet these needs. We have heard the idea expressed that we in public health must recognize the value of the "public health team" in the diagnosis and implementation processes. While this idea has not yet been fully appreciated or widely practiced, it is already obsolete, or at least inadequate. We must think in terms of the "community health team," recognizing the roles and responsibilities of the medical and dental societies, the voluntary health agencies, the public schools, the agricultural agencies, and many others that may exist in the individual community.

An immediate reaction to the ideas expressed here may be that we in public health haven't time to communicate with all these people and to plan with them. It is true that we probably cannot communicate and plan with all of the interested agencies, but we can at least be aware of their roles and their potentials. And we can collaborate with many of the major agencies and organizations in identification of problems and program planning. The truth is that we cannot afford not to find the time for such cooperation.

One of the major problems in most communities is that too many agencies

and civic groups are so busy with the activities of their respective organizations that they haven't time or interest to give to others who may be travelling in the same direction. We are often too compartmentalized and restricted by our own plans, programs, regulations and policies. The health educator can make a significant contribution by being willing, ready, and able to identify areas of collective concern; he can be the catalyst who eventually brings together the persons and agencies who can mobilize sufficient resources to effectively attack selected health problems.

Directors Named to Improve Economic Prospects of Older People

Directors for two nationwide projects aimed at improving the economic prospects of older people have been named by Garson Meyer, president of the National Council On the Aging.

The appointees, both of New York City, are Jack Ossofsky, former administrator of two self-insured labor-management pension plans for the 35,000 members of District 65, Retail-Wholesale Department Store Union, AFL-CIO; and Mrs. Zoe Fales Christman, public relations director from 1947 to 1963 of the Division of Employment, New York State Department of Labor.

As administrator of the Council's contract with the federal Office of Economic Opportunity, Mr. Ossofsky will study established community programs to assist the aged poor. He will draw on successful local experience in these programs and the long experience of the Council itself as the basis for as many as 10 model projects designed to provide services and employment in-

come for the elderly poor.

His final report will recommend action and standards for a full-scale assault on poverty among the aging as a major part of the national War on Poverty.

Mr. Ossofsky has been a pioneer in building organized labor's programs of pre-retirement counseling, and post-retirement social, recreational and community action services.

Mrs. Christman will administer the Council's 18-month contract with the U. S. Department of Labor's Office of Manpower, Automation and Training. The goal is nationwide stimulus of effective training and placement programs for workers 50 years of age and older. She will work with community demonstration projects which are testing techniques for the counseling, training and placement of workers in this age group.

Methods found to be successful will be publicized through a national conference, a documentary film, a series of "how-to-do-it" booklets and other publications. Demonstration projects are under way in Milwaukee, Wis., South Bend, Ind., Boston, Mass. and Baltimore, Md.

Mrs. Christman, who will work closely with the United States Employment Service, helped develop a "grass roots" older worker placement program in New York State which led to no-age-barrier pledges from 24,000 employers.

The National Council On the Aging is a non-profit, non-partisan leadership organization which has been highlighting the needs of the aging since 1950. It advises local, state and federal government agencies and works with industry, labor and other community groups in the interests of the aging.

It also sponsors seminars and conferences, carries out research and publishes reports in the areas of employment, retirement, senior centers, health, housing and institutional care.

Dr. Rankin Resigns As Active Duke Endowment Trustee

Dr. Watson S. Rankin of Charlotte has resigned as a trustee of the Duke Endowment and has been elected Trustee Emeritus.

He will continue as consultant to the endowment's hospital and orphan sections, according to an announcement recently by Thomas L. Perkins, chairman of the trustees.

In retiring from active trusteeship, Dr. Rankin closes 40 years of service which began in January, 1925. Although he was not named as an original trustee by James B. Duke, founder of the endowment, he was selected by Duke and elected just a few weeks after the endowment was created.

He was made director of the hospital and orphan sections in June, 1925, and for the next 25 years his knowledge of health and child care problems in the Carolinas and his talent for communicating with the public were devoted to the development of hospitals, the improvement of medical care in the two states and the interests of orphaned children.

In the 15 years since he resigned as director of the two sections, he has continued to serve through his position as a trustee and as a consultant. He was chairman of the endowment's Committee on Hospitals and Orphanages for 31 years.

For Dr. Rankin, who was 86 January 18, the endowment is one of three careers in which he has distinguished himself. The first was in education and included six years as dean of the Medical School of Wake Forest College, now Bowman Gray School of Medicine at Winston-Salem. The second was the 16 years, 1909 to 1925, when he was

North Carolina's first full-time State Health officer.

Active in organizations concerned with public health and medical care, Dr. Rankin has been greatly honored over the years by his profession. He has been both secretary and president of the Conference of State and Provincial Health Authorities of North America, president of the American Health Association, a trustee of the American Hospital Association, and a member of the North Carolina Medical Care Commission.

He is the author of a number of articles pertaining to public health and hospitals, which have been published in professional journals, and has received the honorary degree of Doctor of Science from Duke University, Davidson College, Wake Forest College, and the University of North Carolina.

The Careful Chauffeur

A short time ago I was talking to a farmer who told me he had just returned from a trip to Oklahoma. He said he had gone there in a pick-up truck to bring back a \$25,000 bull his boss had bought at an auction. He volunteered the information that he had never driven so carefully in his life.

Sensing a story, I asked why he had driven so carefully. With a surprised look, he answered, "I didn't want to hurt the bull or skin him up."

I have repeated this story many times and have always got a chuckle from my listeners. But I'm pretty sure this driver is fairly typical. I believe most drivers would be more safety conscious when chauffeuring a high-priced bull than they would when chauffeuring their own families.

Joseph E. Cannon, M.D., M.P.H.
Rhode Island

Hanes Hosiery Wins 1965 Award for Employee Medical Program

Gordon Hanes, chairman of Hanes Corporation, recently received the 1965 annual award of the Industrial Medical Association honoring Hanes Hosiery Division of Hanes Corporation for development of an outstanding employee medical program. The award, the first ever given to a textile industry company, was presented to Mr. Hanes at the Association's 50th annual meeting banquet at the Americana Hotel by Dr. John A. Palese, division medical director, Liberty Mutual Insurance Company, Chicago. Dr. Charles G. Gunn, Jr., Hanes Hosiery medical director since 1957, also attended.

Hanes Hosiery was cited for "the development of a medical program designed to foster the maximum health of their employees at work and to encourage action on the part of employees in maintaining their physical and emotional well being at all times."

Previous winners of the award which has been made annually since 1949 include, U. S. Steel Corporation, Eastman Kodak Company, Chrysler Corporation, General Motors Corporation, Ford Motor Company, Kaiser Steel Corporation and Humble Oil and Refining Company.

Candidates for the Industrial Medical Association award are judged by a committee of the Association on the excellence of the occupational health program; the imagination by which the program is conceived; the dynamic

manner in which the program is executed; the active participation of management in the program and its tenets; and the participation of the employees, generally, whom the program is designed to serve.

Hanes Hosiery Provides Wide Range Of Medical Services For Employees

Hanes Hosiery Division of Hanes Corporation, in addition to a pre-placement examination of all employees, offers to all management and supervisory personnel a complete physical examination each year. This includes an electrocardiogram and tenometry (measure of the eye ball pressure) for glaucoma detection on all over forty years of age and proctoscopic examination (inspection of the lower bowel) on all men and a cancer smear of the female organs on all women. All employees over forty are offered this same examination as time is available and at present all employees electing to take the examination are seen every 18 to 20 months.

In addition to the examination program, regular x-ray examinations are made for tuberculosis detection. Hanes is the first industry in North Carolina to offer a plant-wide tuberculin skin test in industry. Regular, annual influenza vaccine is offered employees and tetanus immunization is part of the periodic health inventory.

Consultants engaged by the company include a podiatrist (foot specialist) who spends four hours a week in the mill and a psychiatrist who sees five to ten employees a week, helping them with emotional problems. As in the examination program, the emphasis is on prevention rather than treatment of illness.

A staff of four nurses gives advice and counsel, medication when needed, handles all appointments and keeps full records on all employee visits.

Improved Patient Care Purpose of Health Disciplines

The major health disciplines in North Carolina have approved a joint statement of purpose which recognizes improved patient care as their primary mutual objective.

The joint statement was signed by Marion J. Foster, executive secretary of the North Carolina Hospital Association; James E. Barnes, executive director, the Medical Society of the State of North Carolina; Marie B. Noell, executive secretary, the North Carolina State Nurses Association; and Janet Campbell, president of the North Carolina League for Nursing.

H. C. Cranford, Jr. of Durham, Chairman of the North Carolina Committee on Nursing and Patient Care, which sponsored the joint statement, said his

committee will use the document "as a basis for developing a continuing program to improve communication between the disciplines in the interest of our common goal of better patient care for the people of North Carolina."

As a first step in this program, Cranford said, the major disciplines will be asked to publish the statement in its entirety in their respective membership newsletters and to urge full cooperation of their members in carrying out its recommendations and objectives.

The joint statement lists these specific objectives:

To encourage and cooperate in the continuing improvement of patient care through the establishment and operation of a Patient Care Committee in every hospital.

To encourage the invitation of nursing supervisors to attend clinical staff conferences.

To encourage supervisors of other allied departments to attend scientific meetings.

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To encourage full interchange of representatives of the major disciplines at regional, state, and national hospital and medical conferences.

To encourage the exchange of views on matters of mutual concern through publications of the interested groups.

To endeavor to bring about a united presentation to the public of mutual health problems.

"In these and other ways," the statement concludes, "we will strive to promote a more harmonious intramural relationship with other professional and technical organizations in the health field to the end that better patient care will be provided for the people of North Carolina."

The joint statement quotes from the by-laws of the participating agencies to show that each is striving to insure better nursing and patient care for the public as a primary objective.

It adds: "Total patient care today involves all of these major disciplines which in turn require greater coordination, cooperation, understanding and communication between the major disciplines as well as individual recognition that allied professional and technical groups, i.e., laboratory, x-ray, nutrition, physical therapy, etc., are a vital part of the overall effort.

"The individual objectives of the major disciplines for providing health care recognize that the ultimate objective of providing better patient care for the people of North Carolina can best be served by greater cooperation, coordination and communication, not only among themselves but with the various allied agencies representing the technical specialties that have direct responsibility for patient care."

Cranford said the joint statement of the intent and desire of the major health disciplines to work together to improve patient care in a state is so far as the North Carolina Committee on

Nursing and Patient Care knows, the first of its kind in the nation.

Organized in 1950, the North Carolina Committee on Nursing and Patient Care is a quasi-official coordinating agency for major health groups in the state, both governmental and voluntary. It meets quarterly. The Committee is composed of 10 representatives of statewide health organizations and 11 public members.

The principal objective of the committee is "to concern itself with activities involved in providing better patient care in North Carolina." A contributory objective is "to afford a medium for liaison between the three groups primarily and directly responsible for caring for the sick, namely, physicians, nurses and hospital administrators."

Brochure on Graduate Study and Research

The Department of Environmental Sciences and Engineering of the University of North Carolina has just republished its brochure entitled, "Programs of Graduate Study and Research." Special sections are devoted to Career Opportunities, Degrees and Admission Requirements, Financial Assistance, and Programs of Study and Research.

Typical courses of study are outlined for: Sanitary Engineering and Water Resources, Environmental and Food Sanitation, Environmental Chemistry and Biology, Air and Industrial Hygiene and Radiological Hygiene.

Copies of the brochure may be obtained by writing Dr. Daniel A. Okun, Head, Department of Environmental Sciences and Engineering, Box 899, Chapel Hill, North Carolina 27515.

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DATES AND EVENTS

- July 10-16 — American Association for Rehabilitation Therapy, New York, N. Y.
- July 10-17 — Sixth International Conference of the International Union for Health Education, Madrid, Spain.
- July 11-14 — Institute on Tuberculosis and Other Respiratory Diseases, Blue Ridge Assembly, Black Mountain.
- July 11-15 — American Veterinary Medical Association, Portland, Oregon.
- July 25-31 — National Farm Safety Week.
- August 9-12 — National Medical Association, Chicago, Ill.
- August 23-28 — American Academy of Physical Medicine and Rehabilitation, Philadelphia, Penn.
- August 29 - September 2 — American Public Works Association, Los Angeles, Calif.
- September 8-11 — Regional Meeting of National Health Council with National Conference on Community Health Services, San Francisco, Calif.
- September 9 - 11 — Annual Meeting, North Carolina State Employees Association, Battery Park Hotel, Asheville.

- September 13-16 — International Association of Milk and Food Sanitarians, Hartford, Conn.
- September 15-17 — Annual Meeting, North Carolina Public Health Association, Jack Tar Hotel, Durham.
- September 15-18 — Regional Meeting of National Health Council, Chicago, Ill.

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The Official Publication Of The North Carolina State Board of Health

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LEGISLATIVE SUMMARY

**A Review of Health Related Acts
of the 1965 General Assembly**

V. 80, #6, JUNE 1965

Legislative Reference Summary

**On these pages are given Identifying
References to Bills Enacted which have
Health Implications.**

Health Related Acts

(Date given indicates effective date.)

Bill Number	Subject
SB 17	Dental member of Mental Health Council. (3/2/65)
SB 18	Dental member of Medical Care Commission. (3/2/65)
SB 23	Metabolic laboratory. (6/17/65)
SR 27	Commending Cancer Study Commission. (3/30/65)
SB 28	Practice of dentistry. (4/5/65)
SB 44	Abuse and neglect of children. (7/1/65)
SB 72	Poliomyelitis vaccine. (5/21/65)
SB 82	Exemption from civil liability for rendering assistance to injured. (4/6/65)
SB 121	Marriage ceremonies. (4/1/65)
SB 133	Chemical test admissability. (6/17/65)
SB 176	School of Medicine at East Carolina. (6/14/65)
SB 210	Optometric bill. (7/1/65)
SB 228	Practice of nursing. (7/1/65)
SB 233	Operation of funeral establishments. (1/1/66)
SB 234	Licenses to embalmers. (5/28/65)
SB 235	North Carolina Board of Embalmers and Funeral Directors. (5/20/65)

Bill Number Subject

SB 245	Manufacture of bedding. (1/1/66)
SB 320	North Carolina Traffic Safety Authority. (5/14/65)
SB 341	Voluntary sterilization. (6/11/65)
SB 397	Oral surgical services. (1/1/66)
SB 432	Land for Environmental Health Center. (6/10/65)
SB 445	Medical Assistance (6/17/65)
SB 500	Relating to asbestosis or silicosis. (6/10/65)
HB 12	Appropriations for current operations. (Included the 10% State employee salary increase.) (6/10/65—increase effective 7/1/65)
HB 55	Nursing and boarding homes. (3/5/65)
HB 94	Increase per diem of State boards. (2/1/65)
HB 152	Use of dangerous weapons. (6/4/65)
HB 158	Removal of graves. (3/12/65)
HB 179	Deserted wives sterilization consent. (3/24/65)
HB 189	Incorporation of sanitary districts. (3/30/65)
HB 230	Subdivision regulations. (4/7/65)
HB 235	Discharge of hospital patients. (4/15/65)
HB 247	Investments of retirement. (7/1/65)
HB 278	Motor boat sewage treatment. (1/1/66)
HB 418	Refunds of State sales and use tax to sanitary districts. (7/1/65)
HB 423	Service charges and rates of sanitary districts. (6/10/65)
HB 487	Increase by two dollars the subsistence travel allowance for State employees. (7/1/65)
HB 520	Evidence of blood tests. (5/19/65)
HB 536	Annual motor vehicles inspection. (5/28/65)
HB 544	Southern Interstate Nuclear Compact. (6/8/65)
HB 556	Retirement System minimum benefits. (6/17/65)
HB 590	Medical Examiner System in certain counties. (5/20/65)
HB 601	Sanitary districts. (5/11/65)
HB 623	State Personnel Board. (7/1/65)
HB 691	Retirement System. (7/1/65)
HB 692	Local Government Retirement System. (7/1/65)
HB 712	Retirement System, prior service credit. (7/1/65)
HB 860	Capital public health and mental health center reserve funds for counties. (6/11/65)
HB 862	Regulations for shellfish and crustacea. (7/1/65)
HB 892	Drainage district amendments. (6/17/65)
HR 918	Osteopathy bill. (6/10/65)
HB 1004	Ambulance service. (Buncombe, Haywood and Madison). (6/9/65)
HB 1071	False ambulance request. (Buncombe, Haywood, Madison). (6/11/65)
HB 1074	Council on Aging. (7/1/65)
HB 1117	Ambulance regulation. (Cumberland). (6/17/65)
HB 1131	Coroner-medical examiner revisions. (Guilford and Lee). (6/16/65)
HB 1138	Mental health fund transfer. (7/1/65)

If you need a certified copy of any Act, direct your request to the Office of the Secretary of State.

Important Traffic Safety legislation was enacted by the 1965 General Assembly, even in addition to the creation of the N. C. Traffic Safety Authority and the annual Motor Inspection law. Other legislation included: doubling the State's investment in Driver education and extending instruction to all license applicants under 18 whether in school or not; a law requiring new cars sold in the State to have an outside rear view mirror on the driver's side; the creation of a Highway Safety Research Center at UNC; the addition of 50 highway patrolmen in each year of the biennium; and the appropriation of funds to reflectorize license plates in 1967.

New Book Stresses Rural Health Programs

A new book entitled **HEALTH OBJECTIVES FOR THE DEVELOPING SOCIETY**, edited by E. Croft Long, seeks to assess the various responsibilities of the individual, the physician and the community in developing programs in rural health. It is intended to explore some facets of an intriguing, contemporary question. The purpose is to provoke re-statement of an outstanding problem, to direct attention to its urgency, and to generate inspiration for its solution.

The book is the product of a seminar held a little more than a year ago at Duke University with financial assistance from the Ford Foundation.

Outstanding health leaders from Brazil, Canada and the United States are among the contributors. Edward G. McGavran and Robert E. Coker, Jr., well known to North Carolinians, are included in the list of contributors.

With good products and backed by the Dairy Council, National and State, June Dairy Month is always a success. The most recent observance which started with a State-wide luncheon at the Faculty Club in Raleigh at which Mrs. Dan K. Moore was a principal speaker has resulted in new appreciations of the various foods sponsored by the Dairy Association.

The State Radiation Protection Program, an activity of the State Board of Health, made careful readings to determine the effect of the May 13 Chinese atmospheric explosion. The North Carolina readings have been compared with others being made in the National network of the U. S. Public Health Service and are comparable with the findings of other qualified observers.

As of late in May, some slight upward trend in fall-out was noticed though far below the level at which any special concern is given by scientists.

The Health Bulletin

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June, 1965

No. 6

**SUMMARY REPORT
OF
1965 STATE LEGISLATION CONCERNING THE
RESPONSIBILITIES OF THE NORTH CAROLINA
STATE BOARD OF HEALTH AND CERTAIN OTHER
HEALTH RELATED ACTS**

Senate Bills

Senate Bill 23—An act to make an appropriation to the State Board of Health to provide for the continuing support of the laboratory for screening of metabolic diseases of newborn infants.

This appropriation to the State Board of Health makes possible the operating, maintaining, equipping, and the making of necessary repairs to its laboratory for screening metabolic diseases of newborn infants. The appropriation amounted to the sum of \$43,539.00 for the first year of the biennium and the sum of \$44,269.00 for the second year of the biennium. Effective June 17, 1965. (Chapter 1164)

SB 44—An act to confer immunity on physicians and other persons who report physical abuse and neglect of children and to amend sections of the General Statutes to prevent conflict between statutes as to whether the relationship of husband and wife or physician and patient will prevent the introduction of evidence or testimony.

This bill clarifies statutes which protect children from illness or injury as a result of abuse or neglect by a person responsible for the child and confers immunity on the person reporting. Effective July 1, 1965. (Chapter 472)

SB 72—An act to amend G.S. 130-93.1 to provide for appropriation to the State Board of Health for poliomyelitis vaccine.

This makes appropriations for the purchase of poliomyelitis vaccines a part of the State Board of Health's budget. Heretofore, under North Carolina's immunization law, funds for this purpose have been obtained from the Emergency and Contingency Fund. Effective May 21, 1965. (Chapter 652)

SB 133—An act to amend G.S. 20-16.2(b) to provide for a hearing on question of refusal to submit to chemical test provided for under G.S. 20-139.1 and to restrict the admissibility into evidence of the result of such chemical test.

This bill does not change the basic relationships of the State Board of Health with respect to our own program. Effective June 17, 1965. (Chapter 1165)

SB 320—An act creating the North Carolina Traffic Safety Authority.

This Authority composed of certain governmental officials ex-officio is given the responsibility of making a thorough and objective analysis of the State's traffic problem with recommended improvements and additions. The Governor is Chairman. Dr. J. W. R. Norton the State Health Director is a member of the Authority. Effective May 14, 1965. (Chapter 541)

SB 432—An act to appropriate the sum of \$750,000 to the Department of Administration to use for the purchase of land in the Research Triangle Park to make it available to the Federal Government for the Environmental Health Center.

This enables the State to fulfill its agreement with the Department of Health, Education and Welfare that sufficient land would be provided for the construction of this facility. Effective June 10, 1965. (Chapter 902)

SB 445—An act to provide for the establishment of a program of medical assistance in North Carolina.

This act is taken to legally prepare North Carolina in anticipation of Federal legislation which will create a single program of grants to replace various programs now authorized. Effective June 17, 1965. (Chapter 1173)

House Bills

House Bill 12—General Appropriations bill.

Appropriations for current operations. Included in this bill was the 10% State employee salary increase. The last substantial general increase in salaries for State employees was nine years ago. During these intervening years, salaries in other comparable and competitive areas have been increased and living costs have continued to rise. Effective June 10, 1965. Salary increase effective July 1, 1965. (Chapter 914)

HB 189—An act to amend G.S. 130-124 so as to eliminate the requirement that free-holders petitioning for incorporation of a sanitary district be residents of the proposed district.

This makes possible petitions for Sanitary Districts with either 51% of resident freeholders signing or 51% of property owners signing. Will help in some unusual situations where property is owned by other than residents of area to be incorporated. Effective March 30, 1965. (Chapter 135)

HB 278—An act to amend Chapter 75A of the General Statutes relating to motor boats and vessels so as to require sewage treatment of holding devices.

Requires boats on inland waters having toilet facilities to meet requirements of the State Board of Health. Authorizes the State Board of Health to establish standards for marine toilets or holding tanks. Also, prohibits the throwing of trash and garbage into inland lake waters. Effective January 1, 1966. (Chapter 634)

SB 487—An act to amend Chapter 138 of the General Statutes so as to increase by two dollars the subsistence travel allowance for State officers and employees.

This act makes more realistic the travel budget of State employees who must travel to carry out their official responsibilities. Travel allowance for in-State is now twelve dollars (\$12) and for out-of-State sixteen dollars (\$16). Effective July 1, 1965. (Chapter 1089)

HB 536—An act to provide for annual safety equipment inspection of motor vehicles.

This is a major part of Governor Moore's highway safety program and provides for an annual safety equipment inspection of motor vehicles. A staggering of dates during which vehicles are to be inspected makes the program reasonable as does also inclusion of practically all regular garages as licensed inspectors. Effective May 28, 1965. (Chapter 734)

HB 590—An act to establish the county medical examiner system and to abolish the Office of Coroner in certain counties.

This act sets up in 13 counties a medical examiner system under the Board of County Commissioners. These counties will operate independently of the N. C. Medicolegal Examination Committee. In each county covered by the new law, the office of coroner is abolished. Counties governed by this particular act include the following: Alamance, Catawba, Durham, Forsyth, Granville, Iredell, Mecklenburg, Nash, New Hanover, Polk, Rockingham, Vance and Watauga Counties. Effective May 20, 1965. (Chapter 639)

HB 623—An act to abolish the Merit System Council and the State Personnel Council, and to establish a State Personnel Board responsible for a system of personnel administration under the governor.

This act transfers all responsibilities of the Merit System Council and the State Personnel Council to one single State Personnel Board. For the first time, all county personnel may be included in the personnel under the jurisdiction of the new Board unless the county itself sets up a county plan approved by the State Personnel Board. Essentially all rules and regulations in effect prior to July 1, 1965, remain in effect subject only to future actions of the new Board. Effective July 1, 1965. (Chapter 640)

HB 712—An act to amend Chapter 135 of the General Statutes relating to the Teachers' and State Employees' Retirement System with respect to prior service credit.

This act remedies a situation where an individual has had many years of service in State government but such service has been interrupted. Previously this interruption disqualified the person for prior service credit. Effective July 1, 1965. (Chapter 924)

HB 860—An act to authorize counties to establish capital public health and mental health center reserve funds.

This permits counties to establish reserve funds under appropriate trust fund regulations with which to care for capital needs at some future time. Effective June 11, 1965. (Chapter 963)

HB 862—An act to clarify the authority of the State Board of Health to regulate sanitary aspects of harvesting, processing, and handling shellfish and crustacea and to provide for the transfer of certain property and employees.

This act transfers sanitation authority over shellfish and crustacea from Commercial Fisheries to the State Board of Health. This action legalizes a long time cooperative program and gives State Board of Health enforcement authority which we have not had in the past. Effective July 1, 1965. (Chapter 783)

HB 1074—An act to establish in the Department of Administration a State of North Carolina Governor's Coordinating Council on Aging to provide the organization framework for better and more full governmental and community action in connection with the needs, problems and opportunities of the aged and the aging.

This act makes the emphasis on aging an official part of State government rather than the advisory status of the work done under the North Carolina Governor's Coordinating Council on Aging. The work will be enlarged and a full time executive director and staff will be named. Recent Federal legislation assures additional supportive funds. This new act puts the emphasis on aging in a proper legal setting to receive such Federal funds. Effective July 1, 1965. (Chapter 977)

North Carolina Heart Association Names New Officers

Dr. Robert Cordell, assistant professor of surgery at Bowman Gray School of Medicine, has been named vice-president and president-elect of the North Carolina Heart Association.

The Winston-Salem surgeon was director of surgical research at Bowman Gray from 1957 to 1959. He has served as chairman of the state heart group's research committee since 1963.

Other new officers of the state heart group, elected at the Sixteenth Annual Meeting of the North Carolina Heart Association, held in Durham May 20-21, are Hubert Leonard, Thomasville, as secretary, and James F. Lane, Chapel Hill, as treasurer. Dr. Daniel T. Young, of UNC School of Medicine, Chapel Hill, is the new president of the North Carolina Heart Association, succeeding Dr. Herbert O. Sieker, Durham.

Elected to membership to the North Carolina Heart Association's board of directors, for three-year terms, are Mrs. Allen Barbee, Spring Hope; Horace H. Carter, Shelby; Dr. Joe W. Frazer, Jr., Greensboro; William E. Gifford, Jr., Morganton; Ray King, Charlotte; Fred W. Klein, Leaksville; Dr. James A. McFarland, Rutherfordton; Dr. Robert Mc-

Some 700 North Carolinians attended the North Carolina Heart Association's 16th Annual Meeting and Scientific Sessions, recently held in Durham. Among many participants were, above, Mrs. Dan K. Moore, who honored award recipients at a special breakfast; Dr. Herbert O. Sieker, of Durham, retiring president of the state heart group; and actor Burl Ives, part-time resident of Durham and a leading promoter of Heart Association work. Dr. Daniel T. Young, UNC Heart specialist, was installed as Dr. Sieker's successor at the meeting. (Heart News Bureau photo)



Kone, Winston-Salem; Dr. Ellis L. Rolett, Chapel Hill; Dr. David Sabiston, Durham; Mr. Madison S. Spach, Durham; and Benjamin T. Tison, III, Durham. Elected for a two-year term is Dr. W. A. Current, Gastonia, and for a one-year term, Mrs. John H. McLean, Kinston.

Continuing members of the board are Edwin B. Abbott, Raleigh; Rev. Roy E. Bell, Concord; Dr. Edward P. Benbow, Greensboro; R. B. Boyd, Charlotte; Dr. W. A. Cleland, Durham; Dr. E. Harvey Estes, Jr., Durham; Dr. Walter L. Floyd, Durham; Dr. Roy O. Freeman, Jefferson; Dr. Carl Gottschalk, Chapel Hill; Dr. Harold D. Green, Winston-Salem; Dr. Herbert S. Harned, Jr., Chapel Hill; Dr. Maxwell Little, Winston-Salem; William L. Ivey, Chapel Hill; Mrs. Robert D. McCall, High Point; Dr. Henry D. McIntosh, Durham; Dr. Robert L. McMillan, Winston-Salem; Richard D. Meisky, High Point; Dr. Henry S. Miller, Jr., Winston-Salem; Dr. Ralph S. Morgan, Sylva; Dr. Edward S. Orgain, Durham; Dr. N. W. Sacrinity, Leaksville; Dr. C. Glenn Sawyer, Winston-Salem; Dr. John G. Smith, Rocky Mount; Mrs. H. H. Strandberg, Jr., Rocky Mount; Shirley F. Woodell, Chapel Hill; and Dr. William B. Young, Wilson.

Hargrove Bowles, Jr., Greensboro, and Dr. J. Logan Irvin, Chapel Hill, are chairman and vice-chairman of the board.

The Planning staff of the North Carolina Council on Mental Retardation is seeking to initiate study groups in each of the State's 100 counties. It is the hope of the Council that community self-study and planning will increase the local services to the mentally retarded.

Herbert Shore Heads American Association of Homes for Aging

The American Association of Homes for the Aging, the national membership organization of non-profit voluntary and governmental Homes for the aged, has elected as its President, Herbert Shore, Executive Director of the Dallas Home for Jewish Aged. He succeeds The Rev. Canon Herbert C. Lazenby, Executive Director of Episcopal Community Relations, Diocese of Olympia, Seattle, Washington.

Elected to serve as Vice Presidents of the Association were Reverend William T. Eggers, Administrator, Home for Aged Lutherans, Wauwatosa, Wisconsin; attorney Thomas M. Jenkins, current President of the United Community Fund of San Francisco; and, to a second term of office, architect I. S. Loewenberg, a member of the Mayor's Commission for Senior Citizens of Chicago and of the Advisory Council on the Improvement of the Economic and Social Status of Older People for the State of Illinois.

Completing AAHA's slate of officers are Mother M. Bernadette de Lourdes, O. Carm., Administrator of St. Joseph's Manor, Trumbull, Connecticut, elected Secretary; and Dr. Edward P. O'Rear, General Manager, Pacific Homes, Los Angeles, California, re-elected Treasurer.

Mr. Shore, whose term of office as AAHA President began in January, 1965, has earned national recognition as a leader in the field of aging. He is

a past President of the Texas Gerontological Society, the Texas Society on Aging, the National Association of Jewish Homes for Aged, and a former Vice President of the Texas Association of Voluntary Non-profit Homes for Aged.

Among the national, regional and local organizations in which he holds memberships are the National Association of Social Workers, the National Council on Aging, the Adult Education Association, the American Hospital Association, the National Conference of Social Work, the Dallas and Texas Mental Health Society, and the Dallas and Texas Social Welfare Association.

A graduate of the New York School for Social Work, Columbia University, Mr. Shore was a group worker in New York community centers for five years, and in 1950 assumed the post of Assistant Director of Drexel Home, Chicago. He was appointed Director of Golden Acres, the Dallas Home for Jewish Aged, in 1953.

Mr. Shore has edited and contributed to numerous publications and books, and is co-author with Dr. Morton M. Leeds of the current work "Institutional Geriatrics Management" published by Putnam's.

A Doctoral candidate at North Texas State University, he has received faculty appointments at University of Texas Southwestern Medical School and the School of Social Work, North Texas State University and the Worden School of Social Work.

The American Association of Homes for the Aging serves more than 80,000 elderly residents of its 550 member non-profit institutions through national programs of technical assistance, public information and education, and liaison and consultation with government agencies and legislative committees at all levels.

Hill-Burton Projects Center on Responsibility for Dispensing Drugs

The hospital nurse will be relieved of the responsibility of dispensing drugs—and it will be placed with the pharmacist where it legally belongs—if two Hill-Burton research projects bear fruit as expected.

The two research investigations, sponsored by the Hill-Burton program, administered by the Public Health Service, U. S. Department of Health, Education, and Welfare, are among the approximately 200 projects listed in "Hos-

pital Administrative Research," Public Health Service Publication No. 930-C-8. Both studies involve revised methods for distribution of drugs in hospitals, designed to enhance safety and efficiency in their administration.

Federal grants to finance these studies were made to research workers at the University of Arkansas Medical Center and at the University of Iowa. Both experimental systems involve unit-dose dispensing by a pharmacist, although the University of Iowa study envisages pharmacy substations while the University of Arkansas group uses a central pharmacy with all paper work involving drugs automated by the use of electronic equipment.

The research projects described in the recently issued publication are grouped under four major headings: Community Planning, Design and Construction, Organization and Administration, and Services.

Menu planning by computer, methods of measuring hospital obsolescence, the use of automation and data processing in hospitals, and improvements in patient care are among the kinds of research undertaken by the investigators included in the listing. Publications resulting from the research are also noted. Further inquiries concerning a specific project should be directed to the principal investigator.

"Hospital Administrative Research" also discusses the types of grants that can be made under the Hill-Burton program.

Quantity orders for this publication should be directed to the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The price is 35 cents per copy. A single free copy may be obtained from the Division of Hospital and Medical Facilities, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C. 20201.

Health Notes

William C. Friday, President of the University of North Carolina, has been named State Chairman of the 1966 Heart Fund Campaign. He succeeds Mrs. J. Spencer Love, of Greensboro, who headed the highly successful 1964-65 Drive.

"**Impact for Tomorrow**" is the theme for the 1965 annual convention of the National Society for Crippled Children and Adults. This organization, the Easter Seal Society, will meet November 19-22 at the Palmer House in Chicago.

Retraining Older People

Garson Meyer, president of the National Council on the Aging, Inc., New York City, has announced the appointment of Miss Irma Rittenhouse as research director for the NCOA demonstration project on retraining and re-employment of unemployed older workers.

The project, being carried out under a contract with the federal Office of Manpower, Automation and Training, involves four community action programs now in progress and three more in the planning stage.

Miss Rittenhouse is former Director of Research of the Division of Employment, New York State Department of Labor.

How North Carolina Got the Federal Environmental Health Center (As Viewed by a Pennsylvania Competitor)

THE MULTI-million-dollar Federal environmental health center, sought by Harrisburg and other Pennsylvania communities will be built in North Carolina.

Our area should have had everything going for it.

Right off the bat, there would have been a saving of \$25 million in construction of new buildings by utilizing a part of the Olmsted Air Base complex, marked for abandonment by the Defense Department.

* * *

THERE was also the attraction of the new Hershey Medical School, soon to be built as the most modern in the world—a graduate center that could have been meshed ideally into the needs of the environmental health center personnel.

There is the area's reasonable access to the graduate schools in Philadelphia and the Pennsylvania State University—a location every bit as good in this respect as in the North Carolina "research triangle" based on the University of North Carolina at Chapel Hill, North Carolina State at Raleigh and Duke University at Durham.

There is the added advantage of this area's geography—far easier access to the long-established Federal Research Center at Beltsville, Md., and to Washington.

Philadelphia also could make out a very strong case as a site for the new facility, certainly as good as North Carolina's. So could several other Pennsylvania communities.

But Pennsylvania lost out just the same, and North Carolina won—and never mind the cynic's observation that Carolina is perhaps more politically friendly countryside to the present Democratic administration.

There's no use crying over spilled milk—or spilled Federal largesse. And let's face it: North Carolina gave Pennsylvanians a lesson in how to go about industrial development—Federal Government division.

The Harrisburg area didn't even start going after the big Federal center until

late summer—and then not really seriously until the Olmsted closing announcement shook Central Pennsylvania to its very economic foundations. Other Pennsylvania communities started even later. A few started earlier—but not by much.

North Carolina was in the battle for this big Federal installation from the first moment there was any indication that one was being planned. That was more than three years ago!

North Carolina obviously has better lines of communication out in Washington than does Pennsylvania. North Carolinians also could give us a lesson in being alert—obviously.

There's the not-inconsequential consideration that North Carolina went after this center as a unified state. There was one prime location offered from the very beginning.

As opposed to this, there were at least six Pennsylvania communities competing with each other in addition to North Carolina and all the other states — Harrisburg, Philadelphia, Pittsburgh, University Park-State College,

Scranton-Wilkes-Barre, the Lehigh Valley. There may have been more.

Individual congressmen and Pennsylvania's senators threw what political weight around that they could, helped to open up whatever doors they could to ambassadors from the various communities of our Commonwealth. As opposed to this, the entire North Carolina congressional delegation was united from the very beginning, and threw its weight around en masse.

* * *

IT'S TRUE, of course, that North Carolina is a smaller state, and this probably can be accomplished more easily. But just the same, it seems to us, there should be far greater effort made in the future to unify and coordinate Pennsylvania's powerful congressional delegation on Federal quests of this kind.

North Carolina gave all of us in Pennsylvania a lesson on how to go about it.

Let us take that lesson to heart.

—Selected

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What Parents Should Know About Refrigerator- Entrapment Accidents of Small Children

Most refrigerator-entrapment accidents happen to children under 6 years of age. Empty refrigerators appeal to children of these years as attractive places in which to play. They are shaped like "playhouses"; they make good "jails," they are fun to play "hide-and-seek" in. Occasionally, a child pushes another into a refrigerator to tease or "scare" him. The game, however, is over the moment the door closes. There is usually only enough air to keep the child alive for 10 to 15 minutes. If the refrigerator is new, with a door which

may be pushed open from the inside, he may be able to release himself, but that is not assured. If he cannot release himself, someone must do it for him. **Any time that a young child turns up missing, a first place to look is in the refrigerator, freezer, or other type of airless enclosure in the home or immediate neighborhood.** Vacant houses, apartments, and junk lots should be immediately suspect.

There are three ways to protect the child from refrigerator entrapment:

1. Supervise his play.
2. "Child-proof" your own refrigerator if it is to be put out of use temporarily or permanently; see that your neighbor does the same with his.
3. Teach your child what he needs to know about refrigerators, ice boxes, and home freezers:
 - a. That he should stay away from them—tell him they are not playthings.
 - b. If a child gets inside of such an appliance, he may not be able to get out without help; no one will hear him if he cries; he cannot be seen; he may not be able to breathe.
 - c. To report to parents any discarded home freezers, refrigerators, or ice boxes he sees in the neighborhood so that his parents can check with their owners on their safety.
 - d. That it is not "funny" but very wrong to push another child into such an enclosure and is absolutely forbidden.
 - e. If he sees another child push a playmate into a refrigerator, he should help him out immediately if he can, but waste no time in reporting the predicament to an adult.

From U. S. Government Pamphlet

THE HEALTH BULLETIN
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DATES AND EVENTS

July 25-31 — National Farm Safety Week.
August 9-12 — National Medical Association, Chicago, Ill.
August 23-28 — American Academy of Physical Medicine and Rehabilitation, Philadelphia, Penn.
August 29 - September 2 — American Public Works Association, Los Angeles, Calif.
September 8-11 — Regional Meeting of National Health Council with National Conference on Community Health Services, San Francisco, Calif.
September 9-11 — Annual Meeting, North Carolina State Employees Association, Battery Park Hotel, Asheville.
September 13-16 — International Association of Milk and Food Sanitarians, Hartford, Conn.
September 15-17 — Annual Meeting, North Carolina Public Health Association, Jack Tar Hotel, Durham.
September 15-18 — Regional Meeting of National Health Council, Chicago, Ill.
September 17-18 — Annual Meeting, North Carolina Association for Retarded Children, Charlotte.

September 22-25 — Regional Meeting of National Health Council, Atlanta, Ga.

September 29 - October 2 — Regional Meeting of National Health Council, Philadelphia, Penn.

September 29 - October 2 — National Association for Retarded Children (Annual Meeting), New York, N. Y.

September 29 - October 3 — Annual Meeting, Planned Parenthood - World Population, New York, N. Y.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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Reaching "Hard-to-Reach" Families

V. 80, # 7

July 1965

N. C. Medical Society President Advises Keeping Voluntary Insurance

THE President of the State Medical Society has cautioned persons over 65 years of age against abandoning or reducing any existing hospital or health insurance plan they may have in effect solely on the prospect of immediate assistance under the "medicare" legislation recently enacted by Congress and signed into law by the President.

George W. Paschal, Jr., M.D. of Raleigh, President of the Medical Society of the State of North Carolina, pointed out that the government's hospital and medical plan for the non-assisted aged under the Social Security system will not provide benefits until July 1, 1966.

Dr. Paschal urged the thousands of North Carolinians age 65 and older who are currently enrolled in voluntary health insurance plans to make certain they maintain their coverage under such programs which provide them with broad protection against the larger costs of needed health services, certainly until the benefits available under the government's program become effective.

Even after the government program is established, he said, it would be most advisable for people age 65 years and older not to discontinue their voluntary health insurance policies unless and until

they have compared carefully the broad coverage, deductible implications, and minimal restrictions guaranteed by these policies with the narrow coverage and complex administrative rules and regulations of the government's plans.



July, 1965

Reaching

"Hard - to - Reach"

Families

IN recent years families who fail to use available health and welfare services in spite of their great need for them have come to be known more as "unreached" than "hard-to-reach." As professional health and welfare workers have reached out to these people instead of expecting them to do all the reaching, they have found many families willing to respond to their help.¹

Special projects in Minnesota, Vermont and Iowa have demonstrated that giving parents hope, courage, self-respect and social acceptance has made it possible for them to create a more healthful atmosphere for their children.²⁻⁴

UNDERSTANDING—THE FIRST STEP

Cahill suggests that public health nurses and social caseworkers, those most closely involved in working with the lower socioeconomic classes, often lack understanding of the differences between themselves and the people to whom they make their services available. Most of them are individuals from the middle class, and they may have a distorted picture of the lower socioeconomic class.⁵

One of the important differences to be understood is the way in which the two classes approach a problem. The middle class will generally attack a problem with initiative while the lower class tends to be resigned and to blame fate or luck.⁵ Broken clinic appointments, seeming apathy about the health and welfare of their children and lack of cooperation with agency workers appear to be natural responses of these parents to the fight for mere existence amid malignant social and economic conditions.^{6, 7}

The "unreached" often express hostility toward persons of authority, possibly because they have come to expect criticism or unrealistic demands from these persons. Taking a child to a

well-baby clinic, as she is urged to do, may mean a mother with very low income must pay two bus fares rather than buy two loaves of bread.^{1, 6}

Perhaps a caseworker is too willing to brand a mother as "dull and unresponsive" in the face of overwhelming threat to her family, without realizing that her mentality or her health may make it impossible for her to cope with the multiplicity of problems confronting her.^{1, 7}

Even marriage as it is known to the middle class does not exist in the lower classes. The man dominates the woman and is often absent from home. Companionship is lacking in this relationship. Often a stable relationship does not exist in this male dominated culture. Among the Puerto Rican and Negro groups in many of our large cities, women are frequently more employable than men, which adds additional pressures to the marriage.⁵

Cultural Differences

In this country where many cultures exist, health programs to be effective must be translated into "individual and cultural terms." For example, it is important to know that persons from southern Italy "regard children as such an integral part of family life that they are expected to rise and sleep on the schedule of their elders and to be included in all family events." Therefore, it is not reasonable to expect these families to conform to the general idea that it is healthy for children to go to bed some hours before the adults.⁸

Likewise, handling any nutritional or special diet problem in the child of a Puerto Rican family must take into consideration that this "father-authoritarian" culture requires fathers to be fed before women and children.

Frequently health instructions given in prenatal clinics can cause confusion or resistance. "We may be urging expectant mothers to reduce the starch in their diet at the same time their mothers are encouraging them in the belief that only 'pasta', with red, blood-making vegetables and olive oil can really build a large and healthy baby. We may ask them to take exercise, while their folklore forbids this as inductive to early parturition."⁸

The Health Bulletin

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Editor—Edwin S. Preston, M.A., LL.D.

Vol. 80 July, 1965 No. 7

It has been the experience of health workers that "no amount of exhortation or allusion to the 'science' of a program will magically transmute it into action against warmly felt family feelings."⁸

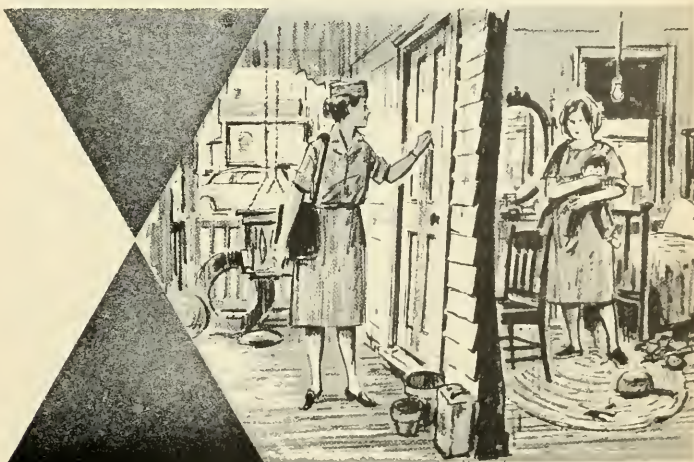
Family Strengths Exist

Those involved in intensive casework with the "unreached" have been surprised to find many strengths in these families, particularly in the area of child care. One study of the rehabilitation potential of families on Aid to Dependent Children showed that while they had problems in many areas they gave their children good care.⁹

"When the great handicaps these mothers were enduring in day-by-day living are considered, the tremendous job they were doing becomes evident. Most of them had to be both mothers and fathers to their children. Though they lacked the emotional support, cooperation and companionship of a husband, they were managing on less than the minimum income considered necessary for health and decency. Their housing conditions were deplorable and their neighborhoods vicious and degrading."⁹

In describing the relationship of the lower-class mother to her child, Cahill says, "She receives her baby passively—an attitude that may be mistaken for indifference or rejection. She handles and communicates with the baby much less than her working-class or middle-class counterpart. She seems to lack the closeness to her child that borders on narcissism—some-

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times seen in the middle class—probably because she regards the baby as a separate individual much earlier.⁵

"The lower class mother will continue to relate to her child as she did to her infant. She nurtures him, but does it with less involvement and tension than other mothers. She does not play with him or even talk to him very much.

"Punishment is swift and sometimes violent, but there is little use of the threat to withdraw love. To some outsiders, this kind of behavior means rejection. Considering the difficult life situation of most in this class, rejection is probably not uncommon, but it may also be true that love has a different meaning or that it is demonstrated in different ways. Certainly, the continuation of ties between mothers and children into adult life would indicate that the trauma of physical punishment did not mean rejection."

Children are taught the rudiments of politeness and parents are quite successful in developing respect for and obedience to elders in the family. "There are some attempts to control aggression but, since the parent 'acts out' aggression so violently in punishing, this trait is not actually curbed. It has value in the culture and probably is encouraged in many ways unconsciously."⁵

LEARNING TO COMMUNICATE

In addition to the problems of communicating over class and cultural barriers, the "unreached" and the health or social worker trying to assist them have many other communications problems.

For the "unreached" family there is first the fact that the worker is a stranger and "we hesitate to reveal our thoughts and feelings and more intimate personal needs until we have a sense of trust in or safety with the other person involved." Frequently there have been previous unsatisfactory agency experiences which have left these people angry and frustrated. Poor vocabulary and limited verbal ability may make it difficult to express themselves or to listen with understanding. Anxiety and lack of insight into the problem can also complicate effective communication.^{5, 10, 11}

The health or social worker must develop considerable skill in interpreting nuances of verbal and nonverbal behavior before the real problems can be detected.¹⁰ In one program directed toward families who do not recognize their basic problems, the caseworkers have helped them learn that talking it out is not a waste of time. They are helped to express their hostilities and frustrations and in this way they gradually become able "to listen and accept the worker's expression of concern and offer of help."¹¹

THE ST. PAUL FAMILY-CENTERED PROJECT

In 1955 a project to reach families resistant to existing services and to provide guides for prevention of family breakdown was initiated by the Greater St. Paul Community Chest and Councils. A voluntary alliance of public and private casework agencies was formed with each agency contributing the services of one or more of its caseworkers to the project. Caseloads, made up of referrals from the seven participating agencies, were limited to 20 families.²

The Families and How They Were Served

All families included in the project had at least one child under 18 and a family situation which represented danger to the child. Each family also presented problems of health, economics or both. The average project family had registered with Public Assistance within 2 years after the marriage took place. In 8 out of 10 families one or both sets of grandparents had been known to social agencies.²

At first each project caseworker tended to continue looking only at the pathology and the limitations of the families in his caseloads. But they soon began to apply the project approach of searching out and using whatever elements of health and growth potential still existed in these families.

First contact with each family was a home visit during which the caseworker explained the specific reason for community concern, such as a child missing school frequently, children left alone at night, or problems with a teen-ager. The need to work with both parents and to see how the family functioned as a unit made a number of evening visits necessary. "And in some cases only by returning again and again in the face of rebuff are we able to convince the family of our concern."

Obviously the rehabilitation of these families did not always proceed as planned. Often after small gains had been made and the family seemed ready to tackle major problems, a breakdown in progress would occur. Then the caseworker would have to determine whether she had been expecting too much too fast and had been taking too active a part in the family's planning. A more realistic step-by-step approach to problems frequently resulted.²

Some Positive Results

Comments from those served by the family-centered project show they felt things were hopeless at the time the project worker first contacted them. Family after family has indicated that the caseworker, through her confidence, enthusiasm and strength, gave them hope and courage and the belief that they could do things differently. From an analysis of the first 100 cases it appears significant positive gains have been made by 67 percent of the families.²

Caseworkers, too, have made gains—greater skills and confidence in dealing with disorganized families. "We no longer like the term 'hard core' or any of the other designations so freely applied to these families. They have taught us much and have guided us to improvement in practice. We have learned with them to face the multiplicity of their problems and together to choose a place to start. We have found that the capacity of the whole family to move ahead step by step often outweighs the pathology of one or more of its members."²

IOWA'S PINE SCHOOL PROJECT

Families in this project are receiving extensive services from a multidisciplinary team in an effort to determine the relation of social, economic and educational deprivation to mental retardation occurring without apparent organic cause throughout a family. It is the cooperative undertaking of the Iowa State Department of Health Maternal and Child Health Division, the Iowa State Department of Welfare and the State University of Iowa.³

In 1957, 19 familially retarded preschool children were enrolled in Pine School, the project's experimental day school. Nine families were represented. All were in or near the lower socioeconomic group and at least one of the parents in each family was mentally retarded. These families lived in standard housing and, though not completely dependent, had required financial assistance in times of economic emergency.

Though the children were given complete medical, psychological and social evaluation and followup care, it soon became obvious that large areas of family life such as child-care methods, homemaking and health practices were being neglected. Therefore, a public health nurse and home economist were added to the staff. With the social worker they visited the families regularly in their homes.

As the demand for home services increased, each worker was assigned three families to visit once each week. She was also available to the other six families when an emergency requiring her skills arose. Early in these home contacts it became apparent that these mothers were very lonely people and that they wanted to improve their homes and their families.

In addition to the individual services, the home economist saw benefits to be derived from group meetings. Not only would such meetings alleviate the loneliness of these women but they would also serve to help them learn more about child care, homemaking and health. The assistance of one of the more enthusiastic mothers was solicited for organizing the group. The hostess, the mother who was providing refreshments and all mothers needing transportation were assisted by the three workers.

"These meetings were obviously very important to these mothers. Only once, at a time of extremely bad weather and

a measles epidemic, was more than one mother missing." Programs have varied from simple craft projects in the beginning to a lecture by the public health nurse on how to tell when a child was too ill to go to school.³

Significant Gains

"Being a member of a group has given these women a sense of belonging. Probably the most important outcome of the meetings for them have been the attainment of friendships and the development of a sense of status within themselves. As they have gained in stature in their own eyes, they have tended to become more adequate. The competition that is usually found among the members of any group has begun to appear. The women have tried to dress as well as their friends, have the house as nice as their friends' houses, and be as clean as their friends."

How has this affected the children in these families? Project workers feel they cannot yet judge, but one interesting fact has presented itself. When six of the younger children reached the age for Pine School and were tested for eligibility, only one of them tested low enough to meet the criterion for admission.³

THE VERMONT PROJECT

In August 1959 a project financed jointly by the Vermont Department of Social Welfare and the Turrell Fund of New Jersey began operation in an area including nine small towns and one small city. All of the families served by the project had economic, marital or health problems which posed a threat to the children; all had difficulty relating to the community.⁴

Six of the project families lived in one of the most deprived and socially isolated areas of the city. The idea of a mothers' group for this area was conceived and five mothers who showed interest in the club were invited to the home of one of the project mothers for the first meeting. When this attempt failed, project workers became aware of the enormity of the task they had set for the hostess. "Not only had she never entertained, she had never been entertained. She had had so few successes in her life that she would not have been able to face it if her neighbors had not liked her home."⁴

A few months later the women did form a club which has been instrumental in beautifying the neighborhood, making a playground for the children, forming 4-H clubs, and achieving a great deal of good publicity for the neighborhood in local newspapers. As a result of all these activities relief costs have dropped in this section of the city, police have been called less frequently and homes are cleaner. "There have been no complaints of child neglect, and school authorities have commented favorably on the change in appearance and attitude of many of the children. One mother, without any suggestion by the

worker, canvassed the community to get parents to take their children to the well-baby clinic, which they had previously ignored."

Evaluation of the Project

A review of the 37 project families in October 1960 showed 21 of them had made enough improvement that the worker, the referral agency and the family itself were able to recognize it. Project workers have found that most families are seeking "self-respect growing out of accomplishment, improved opportunities for their children, a better relationship with and recognition by the community at large."

"Every community has resources needed by those of its families who seem unable to cope with the problems of everyday living. But few such families will use the resources to best advantage, or even at all, unless a caseworker is at hand to reach out to them and give them the courage to go ahead."⁴

OTHER APPROACHES

In Philadelphia, homemaker consultant services are provided for many disadvantaged families when the public health nurse or social worker finds the mother's lack of homemaking skills poses a real threat to the health and welfare of her children. While the homemaker consultant is working with the mother she often finds it necessary to solicit the aid of public and private community agencies to handle the other problems uncovered in the home.¹²

One of the positive results of this program is the ability of these mothers, once some order has been brought out of the chaos in her home and clothes are in good wearing condition, to relate to their neighbors and the community, often for the first time in their lives.¹²

Slum clearance projects in most of our large cities have created numerous relocation problems. Washington, D. C. is taking positive steps to see that these low-income families are provided with social and health services which will reduce the likelihood that slum habits among displaced families will continue in new and better neighborhoods.¹³

The program begins with meetings of the families in small groups to give them explanations of the planned relocation. Individual counseling on planning moves is given and the families have the opportunity to discuss their problems and feelings about relocation. Orientation discussions also include education in basic housekeeping and home planning methods.

The second portion of the program acquaints the families with organizations and services offered in their new communities. For example, a public health nurse instructs residents in how to use the city's health services and assists them in making appointments. She also teaches small groups in prenatal care,

nutrition, accident prevention, infant care, care of the sick at home and babysitting. Casework service to families who need personal counseling to work out their problems supplements both phases of the program and continues after relocation.¹³

BETTER HEALTH FOR THE DISADVANTAGED

To better understand the health attitudes and practices of low-income families, Howard University conducted a 3-year study in Washington, D. C. The findings and conclusions have implications for all health workers, particularly in respect to planning programs for these families.¹⁴

"The responses of both Negro and white families strongly suggest that in a low-income area variations exist among families of the same race not only in regard to income, but also in the range of health knowledge, health habits, health attitudes and utilization of health services. Multifaceted programs have to be developed in order to appeal to the range of interests among the people in these areas."

According to the authors of the study report, health education to be effective must be brought close to where low-income groups live and must be identifiable, and "the consumer and the dispenser must stand on common ground." They suggest the possibility of using professionally supervised practical health educators who "come from the same environment as the families being served, who talk their language, who are well acquainted with their indigenous leaders and who can thus better communicate with them and motivate them toward better health habits."

Another method might be the use of "roving" health educators who would carry health information into "barber shops, pool halls, beauty parlors, or small independent churches."

"All public health agencies need to show a great deal more imagination today in getting their message across to the public that needs it most."¹⁴

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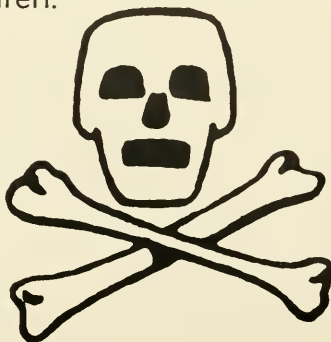
A Plea for Safer Pesticides

IN Clinical Pediatrics, May 1965, Dr. Jay M. Arena, M.D., gives a warning concerning the dangers of poisoning from thallium. Dr. Arena, who is Professor of Pediatrics and Director of the Poison Control Center at the Duke University Medical Center, refers to pesticides such as the one pictured (top and bottom of can) on the opposite page.

Dr. Arena's article, with accompanying case histories, is entitled "Fatal Thallium Poisoning—A Plea for Safer Pesticides" and contains the following paragraphs:

"Poisoning from thallium is on the increase in the United States, even though since 1957 the content of thallium in pesticides has been limited by the Department of Agriculture to 1 per cent. The known thallium trade-named products marketed for use against roaches, water bugs, moles, ants, silver fish, mice, rats and other pests number at least 44, and probably more are available as non-interstate agents.

"Of 72 confirmed cases of thallium poisoning in southern Texas, nine children died and 26 (54%) had permanent central nervous system sequelae consisting of abnormal reflexes, ataxia, tremors, psychosis and mental retardation. The use of this toxic compound as a pesticide should be replaced by other substances which are effective yet safer for children."





THE EPILEPSY FOUNDATION PROVIDES FREE LITERATURE

The Epilepsy Foundation, a national voluntary health organization, recently released a list of publications available to individuals and organizations interested in and concerned with epilepsy. This list includes the following pamphlets:

Epilepsy, Its Causes, Effects and Treatment
 You, Your Child and Epilepsy
 A Patient's Guide to Electroencephalography
 The Story of More Than Two Million People
 Epilepsy, A Survey of State Laws
 National Children's Rehabilitation Center
 Occupational Guides for Epilepsy
 Interviewing Guides for Epilepsy
 Educating Children Who have Epilepsy
 Workmen's Compensation and Epilepsy
 Epilepsy and Insurance

Single copies are available on request, at no charge, and bulk copies will be provided without charge to organizations and professional personnel. These can be secured by writing The Epilepsy Foundation, 1419 H Street, N.W., Washington, D. C.

In addition, The Foundation has completed the 1965 edition of **The Legal Rights of Persons With Epilepsy**, a survey of state laws and administrative policies relating to persons with epilepsy. Professional personnel and organizations may obtain single copies of this document.

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Arthur J. Lesser, M. D. is 1965 Recipient of Martha May Eliot Award

Selection of Dr. Arthur J. Lesser, Deputy Chief of the Children's Bureau, as 1965 recipient of the Martha May Eliot Award has been announced by the Maternal and Child Health Section of the American Public Health Association.

The award, established in 1964 to recognize outstanding contributions to maternal and child health, was presented to Dr. Lesser by Dr. Ruth Freeman, head of the selection committee, at the APHA Executive Committee meeting in New York City June 4.

Dr. Lesser joined the staff of the Children's Bureau in 1941 as a specialist in services for crippled children. From 1952 until February, 1965 when he became Deputy Chief, he served as Director of the Division of Health Services. In this position he played an important role in the development of programs to help mentally retarded children and their families and in the establishment of the Bureau's new maternity and infant care programs.



Dr. Lesser received his undergraduate training at Amherst College, Amherst, Massachusetts. He earned his M.D. at Washington University, St. Louis, Missouri and Master of Public Health at Harvard University.

In 1964 the Maternal and Child Health Section of the American Public Health Association established an award in honor of Dr. Martha May Eliot, Professor of Maternal and Child Health at Harvard School of Public Health, who has made many contributions to the improvement of maternal and child health both here and abroad.

First recipient of the award was Dr. Harold Coe Stuart, Emeritus Professor of Maternal and Child Health at Harvard University and emeritus physician of Boston Children's Hospital.

The award includes a \$1000 grant and a bronze plaque bearing Dr. Eliot's likeness. A similar plaque, inscribed with the names of the recipients, is retained by the American Public Health Association. The award is made possible by Ross Laboratories.

THE HEALTH BULLETIN
P. O. Box 2091
Raleigh, N. C. 27602

DIVISION OF PUBLIC HEALTH
MEDICAL SCHOOL. U. N. C.
CHAPEL HILL. N. C.

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DATES AND EVENTS

- September 8-11 — Regional Meeting of National Health Council with National Conference on Community Health Services, San Francisco, Calif.
- September 9-11 — Annual Meeting, North Carolina State Employees Association, Battery Park Hotel, Asheville.
- September 13-16 — International Association of Milk and Food Sanitarians, Hartford, Conn.
- September 15-17 — Annual Meeting, North Carolina Public Health Association, Jack Tar Hotel, Durham.
- September 15-18 — Regional Meeting of National Health Council, Chicago, Ill.
- September 17-18 — Annual Meeting, North Carolina Association for Retarded Children, Charlotte.
- September 22-25 — Regional Meeting of National Health Council, Atlanta, Ga.
- September 29 - October 2 — Regional Meeting of National Health Council, Philadelphia, Penn.
- September 29 - October 2 — National Association for Retarded Children (Annual Meeting), New York, N. Y.
- September 29 - October 3 — Annual

- Meeting, Planned Parenthood - World Population, New York, N. Y.
- October 7-9—American College of Physicians (Fall Meeting), Miami Beach, Florida.
- October 10-12 — Annual Meeting, N. C. Family Life Conference, Queen Charlotte Hotel, Charlotte.
- October 10-13 — Medical Society of Virginia, Hotel John Marshall, Richmond, Va.
- October 10-14 — Water Pollution Control Federation, Atlantic City, N. J.
- October 13-14 — Congress on Occupational Health, Indianapolis, Ind.
- October 15-16 — Annual Meeting, N. C. Society for Crippled Children and Adults, Inc. The Kings Inn, Greensboro.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health



North Carolina's 4-H King and Queen of Health

Sandra Carter, Route 1, Fletcher, and Larry Horne, Laurinburg, were crowned State 4-H King and Queen of Health in the State Health Pageant held at the William Neal Reynolds Coliseum in Raleigh in July. (See story on page 2.)

V. 80, # 8 AUG. 1965

North Carolina

State 4-H Health

Winners Crowned

SANDRA Carter, Rt. 1, Fletcher, and Larry Horne, Laurinburg, were crowned State King and Queen of Health at the N. C. State Health Pageant July 27 in the William Neal Reynolds Coliseum in Raleigh.

The coronation ceremony followed the health pageant—"The Best Things in Life are Free" presented by the 4-H'ers in Beaufort County.

The health prince and princess are Clyde McSwain III, Salisbury, Rt. 6, and Anna Lee Hawes, Rose Hill.

The top winners in the health program are judged on their achievements in personal, family, and community health activities.

Queen Sandra Carter of Fletcher has worked in Buncombe County with the Oral Polio Vaccine Program as a volunteer. Sandra has also served as a junior leader in all 4-H health activities and has worked with hundreds of 4-H'ers in her home county.

King Larry Horne of Laurinburg has worked closely with the staff of the Scotland County Health Department. Larry prepares bulletin boards, exhibits, and visual aids for use at the health department. He has also served as Junior Chairman of the Scotland County Cancer Society in 1965. He has encouraged all citizens of Scotland Coun-

ty to know better health practices through numerous demonstrations, exhibits, and lectures.

Clyde McSwain III of Salisbury has presented demonstrations, exhibits, and has worked with the 4-H'ers of his county to improve his personal, family and community health. Princess Anna Lee Hawes of Rose Hill has been an outstanding 4-H'er in her county by various charitable activities in the hospitals of her community. Anna has also presented health demonstrations to 4-H'ers and citizens in Duplin County.

Honored in the Blue Ribbon state health group were the following County Kings and Queens of Health: Linda Rumbley, Alamance; Nancy Landen, Anson; Jeanne Teague, Caldwell; Teddy Jones, Craven; Lila Ann Summers and David Hunt, Davidson; Anthony Westbrook, Duplin; Annette Tilley, Durham; Jarvis Cox, Greene; Linda Gail Snipes and Kenneth Clapp, Guilford; Shelia Blanton, Jackson; Linda Kay Haddock, Jones; Diane Small and David Lee, Lenoir; Jane Morris, Mecklenburg;

Dorthy Jean Hubbard, Moore; Sandra Vick, Nash; Larry Thompson, Orange; Linda Bright, Pasquotank; Robert Chandler, Pitt; Nancy Byrd, Randolph; Selwyn Sampson, Robeson; Judith Cozart, Rowan; Elaine Cheatham and Joel Harris, Vance; Marion Barick, Wake; Ann Lewis and Billy Lewis, Wayne.

Sandra and Larry will receive all expense paid trips to the National 4-H Club Week Congress to be held in November at the Conrad Hilton Hotel in Chicago, Illinois. There 6 National health winners will be selected to receive \$500 scholarships.

The North Carolina Health activity and awards are sponsored by the Eli Lilly Company and the Medical Society of the State of North Carolina.

Check Up
on
Your Heart
—
An
Understandable
Explanation
of the
Procedures
in a
Routine
Heart
Examination

REGULAR heart checkups help check heart disease—and there's nothing to disturb you in a routine heart examination. Actually, says the North Carolina Heart Association, the procedure is entirely painless and relatively simple.

Nor is there anything mysterious about the many things your doctor does to examine your heart. The next time you visit your doctor for your regular checkup, see if this isn't so.

There are many tools, methods, and tests including laboratory techniques for observing a patient's condition. The doctor uses those which are appropriate in each patient's case.

First, your doctor will talk to you. He wants to know if you have any complaints. Is there anything new in the way you feel since your previous visit? Your doctor is not making idle conversation. The information you give him is important to his estimate of your heart health status.

Then he'll feel your pulse. The rhythm of the pulse reflects the rhythm of the heart beat.

Your doctor will then take your blood pressure. The instrument he uses will actually take two pressures. This is why a blood pressure reading resembles a fraction. For example, 130/85.

The upper figure is the "systolic" pressure. This is taken at the moment your heart contracts and drives the blood in its chambers into the arteries. The lower figure is the "diastolic" pressure. It's taken at the moment your heart is resting between beats while its pumping chambers refill.

There's another instrument your doctor will use. This is the familiar stethoscope. Through the ear pieces he hears the sound your heart makes when it contracts and when its valves open and close. The doctor listens for the rhythm, pitch and intensity of these and other sounds. If something is wrong with the heart, there may be differences in these sounds from the way they normally sound.

Your doctor will tap your chest with his fingers to get an idea of the size and position of your heart. This is called percussion of the chest. Sometimes the doctor may shine a bright light into your eyes with a special instrument so that he can see the blood vessels at the back of your eyes. These vessels are the only ones he can observe directly for clues to the condition of your circulatory system.

The doctor may also want to check your heart under the fluoroscope. This is a special type of x-ray machine through which he observes the heart in motion, studying its size, shape and position and the way it contracts. If he wants a permanent record of what he sees he will take an x-ray film.

If the doctor suspects heart disease may be present he may take an electrocardiogram. This is a zigzag record or

tracing of the tiny electrical impulse which makes your heart beat. (It does **not** send any electricity into your body!) The test is especially useful to the doctor after a heart attack has occurred. It can often inform him where the muscle is damaged and to what extent.

If the doctor suspects heart disease he may also use laboratory tests to help complete his examination. He may want to check on the kidneys, the lungs or the blood if he suspects heart disease.

The North Carolina Heart Association points out that the earlier heart ailments are diagnosed, the more effectively they can be treated. It emphasizes that almost every heart condition can now be helped by proper treatment.

And if you want a free copy of the booklet, "How the Doctor Examines Your Heart," write to the North Carolina Heart Association, #1 Heart Circle, Chapel Hill, 27514.

The Health Bulletin

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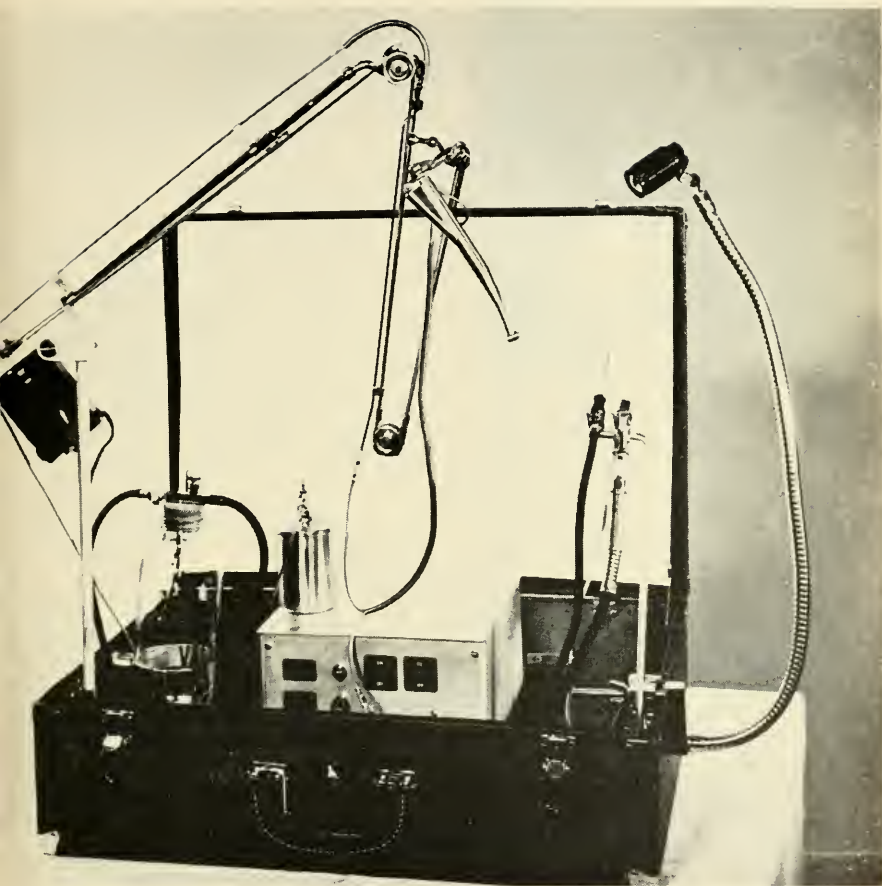
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Vol. 80 August, 1965 No. 8



A Dental Office In A Suitcase

The development of portable equipment permits the dentist to bring dental care to the homes of chronically ill, aged and handicapped patients. In some states departments of health, dental societies and community agencies have purchased equipment and developed projects to provide this care.



New Engineering Section Chief

Lee S. Dukes, formerly with the City of Charlotte Water Department, has joined the State Board of Health staff as Chief of the Engineering Section.

Mr. Dukes is a graduate of Davidson College and received his MSPH from the University of North Carolina. He has been employed by the City of Charlotte as Supervisor of Water and Sewage Treatment for 17 years.

Mr. W. S. McKimmon, who has served as Chief of the Engineering Section since 1952, will continue with the Division as Consultant on Water, Sewerage and Engineering problems.

Small Cars Said to Be More Dangerous

People who drive small foreign cars or American compacts are more likely to be injured or killed in an automobile accident than those who drive standard American cars, so revealed a two-year study of 12,835 cars involved in rural accidents conducted by Cornell's Automotive Crash Injury Research Project.

The frequency of moderate injury was about 10 per cent higher in small cars than in standard cars; the frequency of dangerous and fatal injury was about 20 per cent higher; and the frequency of fatality was about 30 per cent higher in compact cars and 50 per cent higher in small cars.

The main danger in small cars is being thrown through the windshield or out the door during an accident. This is about 60 per cent more likely to happen in small cars and 25 per cent more likely in compact cars. B. J. Campbell, Ph.D., assistant director of the study, explains, "The risk of serious injury is at least twice as great if a person is thrown out of his automobile during a crash than if he remains in the car." Dr. Campbell says the injury risk from ejection could be reduced if all passengers wore seat belts or harnesses and if all cars had safety door latches. These latches were lacking in most foreign cars in the study, although they have been on all U. S. cars since the 1956 models.

—from Family Safety
Summer, 1965

Implanted Heart Pacemaker Not Affected By Electrical Devices

The more than 10,000 American heart patients who have been fitted with implantable electronic pacemakers need have no fear that the pacemaker will be affected by proximity to other electrical devices.

They are free from interference from such appliances as diathermy machines, neon signs, household appliances, radios, TV sets, or other electrical or electronic apparatuses that generate radiofrequency emissions, the Public Health Service's National Heart Institute, U. S. Department of Health, Education and Welfare, has said.

Advisory Committee of Neurological and Sensory Disease Project Plans Educational Programs

Plans for educational activities in North Carolina and progress in the regional screening clinic program at Greenville were reviewed at a recent meeting of the N. C. State Board of Health's Advisory Committee on Neurological and Sensory Diseases.

Several neurologic postgraduate courses designed for physicians are scheduled for the coming months. The Bowman Gray School of Medicine has planned two postgraduate courses in neurology for the near future, although at present, program content and length have not been specifically determined. The first course is scheduled for October, 1965 and will appeal primarily to general practitioners, while the American College of Physicians will sponsor a second and more advanced course in June, 1966.

Dr. George Paulson, Research Neurologist at the N. C. Department of Mental Health, described tentative plans for a one day postgraduate course in neurology for February, 1966, which will



Mrs. Frances S. McConnell, Assistant Professor of Public Health Administration and Advisory Consultant, discusses the regional screening clinic program with Mr. Ted Moore, Project Coordinator from the State Board of Health.

include lecturers from the Duke University Medical Center, the University of North Carolina School of Medicine, and the N. C. Department of Mental Health. Designed primarily for general practitioners, the course will involve both lecture and discussion of practical neurologic problems such as strokes and seizures, as well as case presentations of various neurologic syndromes.

In 1967, the American College of Physicians will sponsor an additional post graduate course in neurology at the Duke University Medical Center.

The State Board of Health has planned educational programs for other professional groups involved with epileptics. Miss Barbara Kahn, Health Education Consultant at the State Board of Health, reported to the Committee that an epilepsy and convulsive disorders conference has been scheduled for August 2 for the vocational rehabilitation counselors located in the counties served by the Pitt County Neurological Evaluation Clinic. A special educational program on epilepsy will also be presented to elementary and secondary school teachers in Greenville in October and November, while a similar program has been arranged for Pitt County teachers at a professional teachers' association meeting.

Regional Screening Clinic

The Advisory Committee also received progress reports on the regional screening clinic in Greenville. The Department of Public Health Administration at the UNC School of Public Health collected and tabulated data on the patients attending the Pitt County Neurological Evaluation Clinic from October, 1964 through May, 1965. Dr. Charles M. Cameron, Jr., Director of the Long Term Illness Evaluation Studies and Professor of Public Health Administration, reviewed this information concerning patient characteristics.

Eighty-five patients received evalua-

tive services during the first eight clinic sessions at the Pitt County Health Department. Of this number, 63 have attended the clinic once, while 22 patients have made a total of 53 return visits.

Patient distribution according to sex and race indicated that 23 white males, 22 white females, 20 non-white males, and 20 non-white females were examined at the Greenville clinic during this period. According to age classification, 30 of the 85 patients were between 0 and 9 years of age, while 25 patients were in the age category of 10 to 19 years of age. Approximately two-thirds of all patients seen at the clinic were under the age of 20. Forty-two of the clinic patients had a convulsive disorder and approximately three-fourths of these were under the age of 20.

Thirty-three physicians have referred a total of 60 patients to the clinic, while the health departments, hospitals or other community agencies have referred the remaining number.

Classification of patients by county of residence shows 49 patients from Pitt, 10 from Craven, 5 from Martin, 4 from Beaufort, 3 each from Halifax and Lenoir, 2 each from Greene, Jones, Chowan and Edgecombe, and 1 each from Washington, Duplin and Bertie.

DR. COLE PRAISES

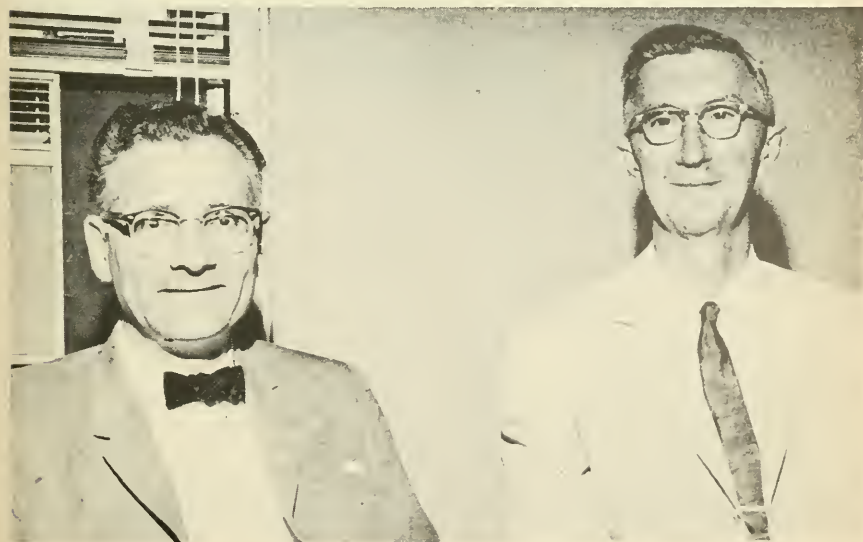
Dr. Clifford H. Cole, Chief of the Neurological and Sensory Disease Service Program of the U. S. Public Health Service, spoke at a recent meeting of the Advisory Committee and praised the North Carolina program in neurological and sensory disease control as "one of the finest demonstrations in the country."

The North Carolina program is one of many activities receiving national support and attention at this time. Dr. Cole mentioned several other programs which have recently been inaugurated.



Dr. Victor Skerrett, from the State Board of Health, represents the Crippled Children's Program which provides medication for children attending the regional clinic.

Dr. Archie T. Coffee, Jr., neurologist from Charlotte, and Dr. Thomas W. Farmer, neurologist from the UNC School of Medicine, meet with the Advisory Committee to discuss educational programs and clinic activities.



**Shift
in the
Nature
of
Narcotic
Problem
is
Mirrored
in
Organization's
Name
Change**

A shift in the nature of the narcotic problem in the four years since the American Social Health Association established its program was mirrored in the recommendation of the Association's National Committee on Narcotic Addiction to change the name of the Association's program from "Narcotic Addiction Program" to "Program in Drug Dependence and Abuse." The recommendation will be presented to ASHA's Board of Directors for final approval at its fall meeting in New York City.

The recommendation was made at a meeting held May 21st in New York

City under the leadership of its newly appointed chairman, Judge Florence M. Kelley, Administrative Judge, Family Court of the State of New York. In keeping with the change, the Association's Advisory Committee will be called the National Committee on Drug Dependence and Abuse.

The proposed change in name, according to the Committee report, reflects a change in the substances used by Americans to modify their mood outside of medical supervision. The use of products like amphetamines, cocaine, or psilocybin, for example, lend themselves to drug abuse but do not meet the traditional criteria of addiction. The report also noted that a young person may engage in glue sniffing and become heavily involved with the practice, although sniffing does not seem to be correlated with established characteristics of addiction like tolerance (the need to increase the dosage), habituation (emotional or psychological need), and dependence (bodily need).

The report stressed that the name change did not reflect a decrease in the problem of persons using drugs that are addicting, like heroin and barbiturates. It also noted that there are persons who take different substances on different days and thus avoid becoming addicted to any one substance.

The World Health Organization has also recommended that the problem be designated by the phrase "Drug Dependence and Abuse." It is possible, under the new terminology, to speak of "drug dependence" of the "morphine type," or of "drug dependence" of any other specific "type."

Among the other matters that were discussed by the ASHA Committee at the May 21st meeting were future directions of the program, the range of consultancy activities of the Association, needed research, services performed under the Association's con-

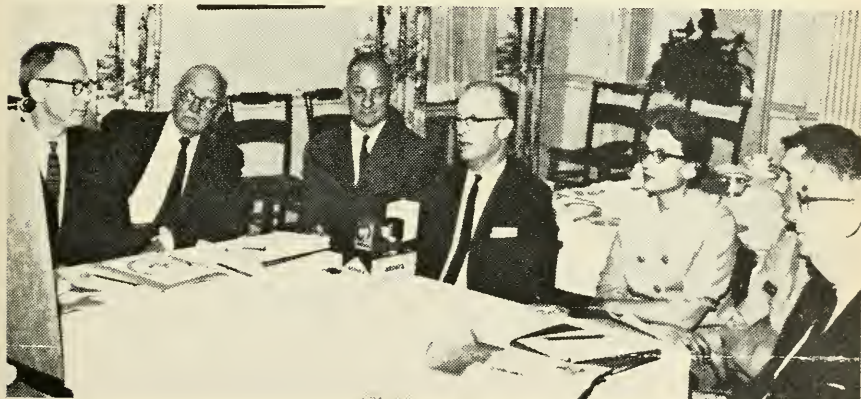
tract with the National Clearing House for Mental Health Information, the forthcoming booklet on the glue sniffing problem, and sources of support.

Members of the Committee who attended the meeting were: Judge Florence Kelley, LL.D., Administrative Judge, Family Court, New York, N. Y.; Frank B. Berry, M.D., LL.D., formerly Assistant Secretary of Defense (Health and Medical), New York, N. Y.; Leon Brill, M.S.W., Director, Washington Heights Demonstration Center, New York City; Nathan B. Eddy, M.D., Consultant, National Institutes of Health, Department of Health, Education and Welfare, Bethesda, Maryland; Joseph H. Douglass, Ph.D., Policy and Program Coordinator, National Institute of Mental Health, Be-

thesda, Maryland; Herbert Sternau, Member of the Board of Directors and Executive Committee, American Social Health Association, New York City; Virgil W. Peterson, LL.D., Operating Director, Chicago Crime Commission, Chicago, Illinois; and Helen L. Witmer, Ph.D., Director, Research Division, U. S. Children's Bureau, Washington, D. C.

ASHA staff members present were Kenneth B. Farris, Director, Public Relations; M. C. Meador, Associate Executive Director; Florence Prescod, Member of the staff of Drug Dependence and Abuse; Conrad Van Hying, Executive Director; and Dr. Charles Winick, Director, Program in Drug Dependence and Abuse.

From Social Health News, June 1965



ASHA North Carolina Committee Holds Meeting

Six members of the American Social Health Association's North Carolina Advisory Committee listen to a report on national program activities by Frank McFall (extreme left), ASHA's Southern Regional Director, at a meeting held in Chapel Hill, North Carolina. Seated from left to right are: Mr. McFall; Capus Wynick, Chairman of the Committee, High Point; James B. Rush, Associate Editor, Winston-Salem Journal and Sentinel; Dr. William L. Fleming, Chairman, Department of Preventive Medicine, University of North Carolina, Chapel Hill; Mrs. Charlotte M. Watkins, Civic Leader, Charlotte; Captain Gallagher, representing Colonel Lloyd L. McDaniel, Provost Marshal, XVIII Airborne Corps, and Walter Anderson, Director, N.C. State Bureau of Investigation.

Two Programs of National Council on the Aging Concern Home-delivered Meals and the Re-location of Older Unemployed Workers

Non-profit home-delivered meals for the ill, handicapped and elderly can and should be an important element of community health and welfare services, a committee on guidelines of the National Council On the Aging concludes. These conclusions are based on a two-year project largely financed by a grant from the Public Health Service.

Further, the committee added, such programs have an appropriate place in therapy, and the promotion and maintenance of physical, mental and social well-being of the individual.

The committee's report offers conclusions, guidelines and recommendations based on findings made during a two-year study in which 102 case histories were analyzed and five programs studied in detail. Data was on hand on 24 known home-delivered meals pro-

grams now in existence in the United States.

"Home-delivered meals," the report states in its conclusions, "should be promoted on the basis of their value as a service to individuals who would benefit from it.

"The dignity and comfort of living in one's home are important personal assets. More than one or a range of services may be needed to attain this goal.

"Further, good nutrition is fundamental to health. Although a meals service is less expensive than institutional care, or than prolonging a hospital stay, it is unsound to promote the service with economy as the overriding factor."

Non-profit home-delivered meals, the committee said, can be well-structured and operated and soundly financed through voluntary or public funds or a combination of both.

Under the volunteer chairmanship of Dr. Ralph E. Dwork, Deputy Secretary of Health of Pennsylvania and the NCOA staff direction of Mrs. Mary F. Champlin, Health Consultant, conclusions, guidelines and recommendations were drawn. The Committee on Guidelines based their report on the work of two subcommittees representing 27 public and private health and welfare organizations. A special NCOA project staff supplied survey findings to the sub-committees.

Although a study of the volume of need was not planned for the project, the committee agreed that the need throughout the country, including rural areas, for a non-profit service of portable meals for the ill, disabled, elderly and other "is of considerable magnitude."

The need will increase with population growth, people living longer, and the trend for older persons to live alone or with elderly relatives, it added.

The committee defined a non-profit program of home-delivered meals as a community service administered by an official or voluntary health or welfare agency.

The service is provided to ill, disabled, and elderly persons and to other persons whose physical, emotional, mental or social conditions handicap their ability to obtain or prepare adequate meals for themselves. Its purpose is to provide, on a regular basis, nourishing meals (including modified diets) as one factor in assisting such persons to lead healthful, wholesome and self-sufficient lives.

In 1962, the report notes in a foreword by NCOA President Garson Meyer, fewer than 1,000 persons were being served in the United States. In Great Britain, where the program was established in 1905, more than 21,000 people benefit from such a program.

"Home-delivered Meals to the Ill, Handicapped, and Elderly," published as a supplement to the May, AMERICAN JOURNAL OF PUBLIC HEALTH, is available from the National Council On the Aging, 104 E. 25th Street, New York, N. Y. 10010. \$1.50.

Re-location of Unemployed Older Workers

A contract between the Department of Labor and the National Council On the Aging to provide a special program of services in South Bend, Indiana, to re-locate older unemployed workers, was announced by NCOA Vice-President and chairman of the Committee on Employment and Retirement Edwin F. Shelley.

"This is the first time society has offered public funds to assist its members faced with the dilemma of having to move to a new geographic area in order to find acceptable and productive em-

ployment," Shelley noted.

Of the 3000 workers over age 50 who lost their jobs in December, 1963, as a result of the Studebaker shutdown, about 2000 have been placed through Project ABLE, another NCOA-Department of Labor program.

Project ABLE—Ability Based on Long Experience through the combined resources of NCOA, the U. S. Employment Service, local health and welfare agencies, and community-wide concern and action, developed employment and re-training opportunities in and near South Bend.

The new research and demonstration project is designed to show that workers over 50, when provided with intensive counselling, financial assistance, and necessary placement and follow-up services, can be satisfactorily placed in jobs in competitive industry in communities sufficiently distant from their home to require a physical re-location of their homes and families. South Bend will again serve as the demonstration area.

"Project ABLE was, frankly, even more successful than we had dared to hope it would be," Shelley said. "This new contract and program will go one step further. We will demonstrate that older workers can profitably find new employment and new lives if they are willing, and helped, to move."

The National Council On the Aging is a non-profit, non-partisan leadership organization which has been highlighting the needs of the aging since 1950. It advises local, state and federal government agencies and works with industry, labor and other community groups in the interest of the aging.

It also sponsors seminars and conferences, carries out research and publishes reports in the areas of employment, retirement, senior centers, health, housing and institutional care.

New Board Members Sworn In

The Oaths of Office for members of the North Carolina State Board of Health were administered August 26th in the Hall of the House of the Capitol Building prior to the regular quarterly meeting of that Board.

Appointees to the State Board of Health by the Governor include: Lenox D. Baker, M.D., Durham (reappointment); A. P. Cline, Sr., D.D.S., Canton; and J. M. Lackey, Hidenite.

Also sworn in were members elected by the Medical Society of the State of North Carolina. These include Joseph S. Hiatt, Jr., M.D., Southern Pines, and Howard Paul Steiger, M.D., Charlotte.

Governor Dan K. Moore welcomed the new members and Chief Justice Emery B. Denny of the Supreme Court administered the Oaths.

MEMBERS OF THE NORTH CAROLINA STATE BOARD OF HEALTH

Lenox D. Baker, M.D., <i>President</i>	Durham
John R. Bender, M.D., <i>Vice-President</i>	Winston-Salem
Ben W. Dawsey, D.V.M.	Gastonia
Glenn L. Hooper, D.D.S.	Dunn
Oscar S. Goodwin, M.D.	Apex
D. T. Redfearn, B.S.	Wadesboro
James S. Raper, M.D.	Asheville
Samuel G. Koonce, Ph.G.	Chadbourn
John S. Rhodes, M.D.	Raleigh

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J. W. R. Norton, M.D., M.P.H.	<i>State Health Director</i>
Jacob Koomen, Jr., M.D., M.P.H.	<i>Assistant State Health Director</i>
J. M. Jarrett, B.S.	<i>Director, Sanitary Engineering Division</i>
Martin P. Hines, D.V.M., M.P.H.	<i>Director, Epidemiology Division</i>
W. Burns Jones, M.D., M.P.H.	<i>Director, Local Health Division</i>
E. A. Pearson, Jr., D.D.S., M.P.H.	<i>Director, Oral Hygiene Division</i>
Lynn G. Maddry, Ph.D., M.S.P.H.	<i>Acting Director, Laboratory Division</i>
Ben Eaton, Jr., A.B., LL.B.	<i>Director, Administrative Services Division</i>
James F. Donnelly, M.D.	<i>Director, Personal Health Division</i>



Interstate Sanitation Seminar a Success

The 1965 Interstate Sanitation Seminar held in Chapel Hill in August was a most successful session. W. Murray Linker, Jr., of the State Board of Health, served as General Chairman of the Executive Committee in planning for the meeting which included five states and the District of Columbia. Leaders shown in the picture from the left are: Dr. William Flash, Chapel Hill, School of Public Health, UNC; Dr. John J. Wright, Chapel Hill, Director, Continued Education Service, School of Public Health, UNC; Dr. J. W. R. Norton, Raleigh, State Health Director; C. H. Atkins, Washington, D. C., Assistant Surgeon General, Chief Sanitary Engineering Officer, U.S.P.H.S., who was the keynote speaker; Dr. Henry E. Turlington, Chapel Hill, pastor, University Baptist Church; Dr. J. Carlyle Sitterson, Chapel Hill, Vice-Chancellor, UNC; and W. Murray Linker, Jr., Raleigh, Seminar Chairman, Supervisor of Specialized Services, Sanitary Engineering Division, State Board of Health.

An informal group conferring at the Seminar (clockwise from the left are): J. M. Jarrett, Raleigh, Sanitary Engineering Division, State Board of Health; Dr. J. W. R. Norton, Raleigh, State Health Director; C. H. Atkins, Washington, D. C., Assistant Surgeon General, Chief Sanitary Engineering Officer, U.S.-P.H.S.; John Andrews, Raleigh, Chief, Sanitation Section, State Board of Health; and Emil T. Chanlett, Professor Sanitary Engineering, School of Public Health, UNC, Chapel Hill.



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DATES AND EVENTS

- September 8-11 — Regional Meeting of National Health Council with National Conference on Community Health Services, San Francisco, Calif.
- September 9-11 — Annual Meeting, North Carolina State Employees Association, Battery Park Hotel, Asheville.
- September 13-16 — International Association of Milk and Food Sanitarians, Hartford, Conn.
- September 15-17 — Annual Meeting, North Carolina Public Health Association, Jack Tar Hotel, Durham.
- September 15-18 — Regional Meeting of National Health Council, Chicago, Ill.
- September 17-18 — Annual Meeting, North Carolina Association for Retarded Children, Charlotte.
- September 22-25 — Regional Meeting of National Health Council, Atlanta, Ga.
- September 29 - October 2 — Regional Meeting of National Health Council, Philadelphia, Penn.
- September 29 - October 2 — National Association for Retarded Children (Annual Meeting), New York, N. Y.
- September 29 - October 3 — Annual

- Meeting, Planned Parenthood - World Population, New York, N. Y.
- October 7-9—American College of Physicians (Fall Meeting), Miami Beach, Florida.
- October 10-12 — Annual Meeting, N. C. Family Life Conference, Queen Charlotte Hotel, Charlotte.
- October 10-13 — Medical Society of Virginia, Hotel John Marshall, Richmond, Va.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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STATE BOARD OF HEALTH—Shown with Governor Moore is the newly constituted State Board of Health as of August 26, 1965, when new members and one who was reappointed were sworn in and new officers elected. Reading from the left—first row are: Dr. A. P. Cline, Sr., Canton; Dr. Howard Paul Steiger, Charlotte; Mr. J. M. Lackey, Rt. 2, Hiddenite; Dr. Joseph S. Hiatt, Jr., Southern Pines; and Dr. James S. Raper, Vice-President, Asheville. Second row: Dr. Ben W. Dawsey, Gastonia; Mr. Samuel G. Koonce, Chadbourn; Dr. J. W. R. Norton, State Health Director; Governor Dan K. Moore; Dr. Lenox D. Baker, President, Durham; Dr. Jacob Koomen, Assistant State Health Director; and Dr. Oscar S. Goodwin, Apex. The two members named to the Executive Committee were; Dr. Ben W. Dawsey and Mr. Samuel G. Koonce.



STATE BOARD OF HEALTH MEMBERS SWORN IN AUGUST 26, 1965—Here are shown the new members and one reappointee of the State Board of Health who were sworn in August 26, 1965, in the Hall of the House of the Capitol Building. Governor Dan K. Moore welcomed the new members and commended the progress attained in the programs of the State Board of Health. Chief Justice Emery B. Denny administered the oath. From the left those shown in the picture are: Governor Moore; Chief Justice Denny; Dr. Lenox D. Baker, President of the Board, Durham; Dr. Joseph S. Hiatt, Jr., Southern Pines; Mr. J. M. Lackey, Rt. 2, Hiddenite; Dr. Howard Paul Steiger, Charlotte; and Dr. A. P. Cline, Sr., Canton.



Public Health's Outstanding Record

Address delivered by Governor Dan K. Moore at the NCPHA Awards Banquet at Durham September 16, 1965.

I appreciate this opportunity to speak to your Association. This organization has served for many years as an outstanding forum in the broad field of public health. The leadership which the North Carolina Public Health Association has contributed to North Carolina is a matter of public record. I am confident that your organization will continue its vital interest, concern and active support for the entire field of public health for all our people.

As Governor of North Carolina, I am aware, of course, of the outstanding record which North Carolina and its 100 counties have made in public health. In fact, you have done your job so well down through the years that many of your services are taken for granted. Yet every time a baby is born, every time a meal is served in a restaurant, every time you drink a glass of water or milk from a public supply, public health services have been at work to assure safe and healthful conditions.

Administration's Purpose Is To Improve Health Services

It is the purpose of my Administration to improve the excellent programs administered by the State Board of Health and by all the state agencies, departments and institutions involved in health. We are fortunate to have strong programs in the Medical Care

Commission, the Department of Mental Health, the system of tuberculosis sanatoriums, the alcoholic rehabilitation program, the Commission for the Blind, and many others.

We also are grateful for the excellent cooperation which has existed between State, local, voluntary and private health organizations and agencies. According to the 1960 census, 47,000 North Carolinians were employed in the health industry. A total of 21,000 of these held professional and technical positions. There is no doubt that this number is increasing rapidly because health care in North Carolina is increasing rapidly. It is estimated there was a 55 per cent increase in the number of health workers in North Carolina between 1950 and 1960.

Never before in the history of our State has there been a greater need for complete coordination of all our health services—State, local, voluntary, private practice, educational institutions and all related fields of health care. This is easier said than done. There are at least 40 health professions involved in providing health care for our people. Private practitioners of medicine, dentistry, nursing, veterinarian medicine, and so forth, have a great responsibility which must never be overlooked. It will take teamwork of the highest order and unselfish cooperation to provide our people with the type of health care, health education and health service which will be required in the months and years ahead.

Excellent Educational Institutions for Health

We are fortunate to have excellent educational institutions in the health field, such as the University of North Carolina, Duke University and the Bowman Gray School of Medicine at Wake Forest College. Preparations are now underway for a two-year medical school

at East Carolina College. Nursing schools are growing in number and quality across the State. For example, four-year nursing schools have been established at the Greensboro and Charlotte campuses of the University, and a two-year nursing school has been approved for Wilmington College.

Good health care is a tremendous resource in North Carolina. If our State is an attractive and inviting place to live, we will attract more graduates in medicine and health care to remain in North Carolina. Good health care is a necessary factor for the proper economic development of any community, county or region in North Carolina. Health care is a vital and necessary activity which must be supported by every community and every county. The State of North Carolina believes in supporting health care and health programs. Through the State Board of Health alone, more than \$8.5 million were expended on health programs during the 1964-65 fiscal year. An additional \$7.5 million came from the counties to be expended on services to the State citizens.

Much of the money—nearly \$3 million—which is channeled through the State Board of Health, goes for direct benefits to residents in the counties, being used for professional and clinic fees in the crippled children program, hospital care payments, polio vaccine, and other purposes.

Adding over \$4 million which came from Federal funds, makes the total of expenditures for last fiscal year a little more than \$16 million. These funds were disbursed through the State Board of Health and the local health departments.

State Board of Health to Administer "Medicare"

I have recently designated the State Board of Health as the official State

agency to administer aspects of Title XVIII of Public Law 89-97, commonly referred to as "Medicare."

I am confident that our State Board of Health will administer this new responsibility as ably as this Board has carried out its present heavy and important health responsibility.

The president of the Board, Dr. Lennox D. Baker of Durham, has evidenced his leadership in many fields. He has a commendable sense of the public needs and the manner in which this new Federal health legislation can meet such needs. Dr. J. W. R. Norton's outstanding leadership of the State Board of Health since 1948 is well known.

In administering "Medicare," the State Board of Health is specifically charged with three responsibilities:

1. The responsibility for certifying that providers of the services under this legislation, including hospitals, nursing homes and home

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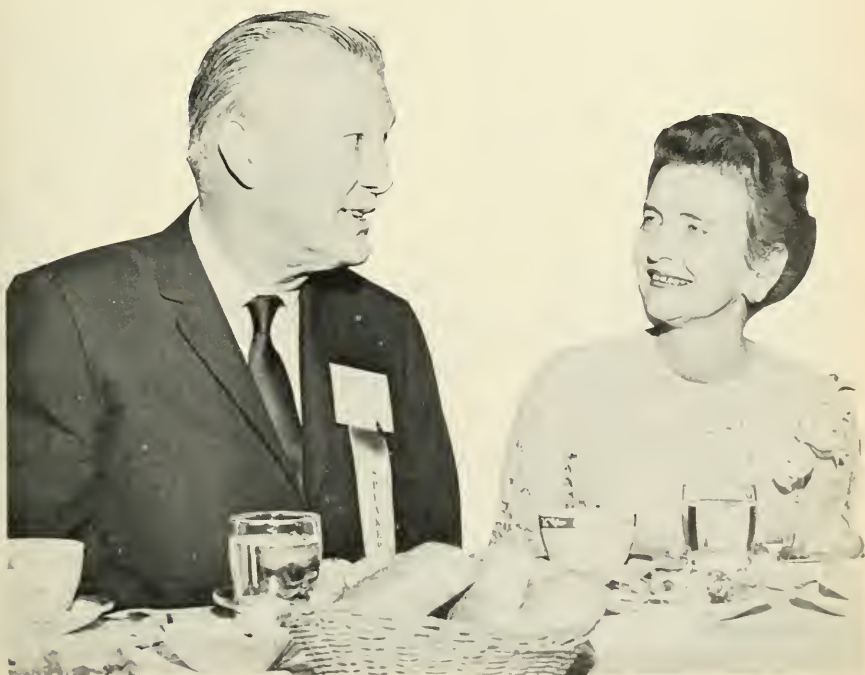
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Vol. 80 September, 1965 No. 9

GOVERNOR EXCHANGES VIEWS

Dr. Isa C. Grant of Elizabeth City, retiring president of the N. C. Public Health Association, chats with Governor Dan K. Moore, who addressed the state convention overflow crowd at the Thursday night banquet session held at the Durham Civic Center.



health programs meet established standards;

2. The Board will be responsible for providing consultation and assistance in establishing "utilization review staff committees" in each institution to review both the quality of care and the length of stay of patients;
3. The State Board will as its final responsibility provide consultation which will assist hospitals, nursing homes and home health programs to participate in this Federal program.

The "Medicare" program will become effective on July 1, 1966.

The coming months will necessitate much advance planning. To unite our efforts toward a common goal, I have directed the State Board of Health to be in consultation during these months with the related local, State and Federal agencies, voluntary health and health-related organizations and with others who may be concerned.

Many Health Fields Deserve Discussion

The field of health is so broad that it would be impossible to make reference to all its facets in this brief address. Surely the growing field of occupational health merits our attention as should water safety, accident prevention, air pollution, dental health, sanitary engineering, health education and public nursing.

The more than a million dollars provided for the needs of crippled children provide further evidence of North Carolina's interest in the health needs of our people. The values of good nutrition, the need for accurate records of births, deaths and marriages and the various ways that available services are presented are other important services.

Programs for Mentally Retarded Are Varied

Public health departments, through the services of the State Board of

Health and other official agencies are meeting their share of the responsibility toward the mentally retarded. As one phase of North Carolina's program to meet this need under the overall statewide leadership of the Advisory Committee on Mental Retardation, these services are being made available to the approximately 140,000 North Carolinians who are mentally retarded. Our excellent State institutions caring for the mentally ill deal with the heavy basic load of providing training and custodial care.

Through the mental retardation program of the State Board of Health, diagnostic evaluation clinics are being held on a continuing basis in seven locations across the State.

Three of these clinics are in the three medical schools of our State. These clinics are serving many children, and in addition put primary emphasis on the training of professional people to attend the mentally retarded.

The Bowman Gray facility has in addition to the training and clinical work an in-patient facility capable of caring for twenty-two patients. This facility focuses primarily on the training of professional people in the field.

Clinics are being held in other locations: one in Asheville which works closely with one at Western Carolina College in Cullowhee. Another is located at East Carolina College in Greenville in cooperation with the county health department.

In addition to these clinic facilities, there are twenty counties in which State funds are being provided to conduct clinics for the child handicapped by mental retardation, speech and hearing difficulties, and other abnormalities. Children are filtered through these county facilities for the more specialized services in the larger centers.

All of the Diagnostic Evaluation Clinics are supported completely by State

NEW NCPHA OFFICERS ELECTED

When the 1965 North Carolina Public Health Association Convention came to a close, these five persons began their one-year term as organization officers. From the left are R. W. Brown of Asheville, president; Mrs. Corrina Sutton of Raleigh, president-elect; Mrs. Mildred Kerbaugh of Raleigh, treasurer; Miss Jane Wentworth, secretary; and Dr. George Dudney of Raleigh, vice-president.



money with the exception of the clinics at UNC Chapel Hill, and Duke University. The twenty-county Child Health Pediatric Clinics are supported solely by State money.

North Carolina is receiving much research money from various sources to conduct health and health-related research. Important health projects include studies in fetal mortality, a testing program for PKU (phenylketonuria), and work in special maternity care grants.

Venereal Disease Presents Threat

The venereal diseases still present a very serious threat to the citizens of North Carolina. The rising trend in the reporting of early syphilis which we have witnessed since 1957 is even more apparent today, and it is a well-established fact that the actual cases occurring far out-number the cases reported. The tragic consequences of venereal disease are resulting in all population groups, but it is particularly disturbing to see the alarming increase of syphilis in our teen-agers.

In spite of this grim picture, progress is being made in most areas of venereal disease control. North Carolina is carrying out a comprehensive statewide control program with special emphasis on the eradication of syphilis, but this is not enough. Our physicians in private practice must recognize the importance of reporting every case of syphilis so that all related infections can be traced and brought to treatment in the shortest possible time. Laboratories must report all reactive tests for syphilis so that health authorities may be assured that every known case of syphilis is under adequate medical supervision.

There is a serious lack of venereal disease education in our public and private schools. We must provide, on a continuing basis as a part of the curric-

ula in our schools, effective venereal disease education for our young people.

State-wide Family Planning Started In This State

In 1937, North Carolina became the first State to start a State-wide birth control program through its county units in public health. This program has been continued and in the past three or four years has been greatly accelerated by the advent of new contraceptive devices for women which have shown themselves to be superior in the prevention of pregnancy.

Public Health Challenges are Changing

The history of public health is essentially a success story. We have every right to be proud of it.

But today, partly as a result of our own success, the conditions have changed. As your leaders have said, the limits of public health are determined by the health needs of the public, the shape and size of the community, and the available medical knowledge and skills for meeting these needs. All three of these factors are changing dramatically from year to year, and even from day to day.

The greatest change of all, of course, has taken place in the size and composition of the public we serve. The population is exploding toward five million before the end of the decade, and will probably approach or surpass the staggering total of 10 million in the next 50 years. It is changing in age-composition, with a rapidly increasing proportion in the above-65 bracket. It is becoming better educated, and gradually raising its economic standards of living.

Moreover, the public is raising its levels of expectations in terms of health care. People read about the wonders of modern medicine. Naturally enough, they want their share. And they expect

these marvels to be conveniently accessible when needed. All of these factors conspire to produce a greatly increased demand for health services of all kinds.

The challenge to the health professions is further complicated by the shift in priority of medical needs—from the communicable to the chronic illnesses, from acute, short-term care to long-term care.

In an age dominated by chronic disease and long-term illness, there must be a new meaning to "preventive medicine." Most of today's major causes of death and disability are not yet preventable, in the traditional sense. But many are detectable in their early stages, thereby reducing complications and permitting early rehabilitative efforts. Prevention in this context becomes disability prevention—a far less costly operation than efforts at salvage operations.

Accidents Pose One of Nation's Greatest Problems

One of the nation's greatest medical problems today is concentrated in the area of accidents. Accidents hospitalize 2,000,000 people each year and cause 8,000,000 more to spend at least one day in bed. It costs the nation 85,000,000 lost work days and 12,000,000 lost school days each year. It is a hard fact of life that accidents are the leading killer of all Americans under 35 years of age.

Traffic accidents are a major cause of death and injury in North Carolina and the nation. To meet this terrible threat to life and property, the General Assembly of North Carolina adopted a far-reaching, broad-scale traffic safety program which I recommended in a special message this spring. I made highway accident prevention a major program in my Administration because the people of North Carolina, and those

charged with official responsibilities in this field, must take positive steps to reduce the mounting toll of death and injuries on our streets and highways.

I shall not dwell on the details of our action program, except to say that the North Carolina Traffic Safety Authority, the North Carolina Traffic Safety Council and the Governor's Office have a common goal—effective action in every area of accident prevention. We can and will reduce the terrible toll of highway accidents. To accomplish this goal, I need your personal support and active participation. Such far-reaching programs can never achieve results without the support of community leaders like yourselves who understand the need for accident prevention.

The forward sweep of scientific knowledge in medical and related fields continues unabated. Our knowledge of prevention, of diagnosis, of treatment, and of rehabilitation mounts steadily.

Our Responsibility Is To Bring Health Benefits to the People

At the same time, it is the responsibility of the public health officials of North Carolina and all those responsible for health care to work together in bringing the benefit of this new knowledge, new techniques, new facilities to all the people of North Carolina. It is not easy, of course, to narrow the gap between health knowledge and its application. Yet we must increase our effectiveness in health service, constantly seeking new and better ways in which to implement man's knowledge in the healing arts and health care.

I know that you who have dedicated your lives to the fine work of public health will be in the forefront of those who lead the cause of good health in the towns and counties of North Carolina.

NORTH CAROLINA PUBLIC HEALTH ASSOCIATION PRESENTS AWARDS

The 54th Annual Meeting of the North Carolina Public Health Association was held September 15-17, 1965, at the Jack Tar Hotel in Durham. Total registration for the Meeting was 969.

AWARDS PRESENTED AT THE BANQUET SESSION OF THE NCPHA MEETING IN DURHAM:

The Carl V. Reynolds Award: Given to an individual for outstanding contributions to public health in North Carolina during the past year for meritorious service above and beyond the call of duty.

The Carl V. Reynolds Award was presented to **Mrs. Pauline J. Bateman**, of Plymouth, for her outstanding work in the field of public health, especially in the development of the pioneer project in a rural health department in North Carolina to define the role of the clinical aide in the public health nursing program.

The Watson S. Rankin Award: Given to an individual in recognition of outstanding contributions to public health in North Carolina over a period of several years.

The Watson S. Rankin Award was given to **Dr. Everett Hews Ellinwood**, of Greensboro, for his devotion to the development of programs in public health and particularly in his direction of the one local health department in North Carolina that has twice won the Merit Award for its outstanding achievements.

The Merit Award: Given to a local health department or group for outstanding contributions or activities during the past year.

The Group Merit Award was given to the **Alleghany-Ashe-Watauga District Health Department** because this spirited staff, under the direction of Mary B. H. Michal, M.D., M.P.H., is accomplishing an outstanding health service for its citizens and visitors despite inadequate staff, inadequate financing and mountainous terrain.

The Merit Citation: Given to an individual for outstanding contribution in working with a special project during the past year.

The Merit Citation was given to **Dr. Annie Vellna Scott**, of Chapel Hill, in recognition of her long years of dedicated and unselfish service as pediatrician, clinician, teacher, educator and her many achievements with broad public health application.

The Merit Citation was awarded to **Mrs. John Barham Spilman**, of Greenville, who accepted the task of coordinating citizen interest in Mental Health back in 1957 and has led the organization which she represents to outstanding growth and achievement.

The Distinguished Service Citation: This award given to recognize individuals in other organizations or professions who have made significant contributions to public health in North Carolina.

The Distinguished Service Citation was awarded to **Senator Julian Russell Allsbrook**, of Roanoke Rapids, for his genuine interest in the Public Health needs of citizens in all walks of life, for his unselfish and untiring efforts in thoroughly apprising himself of these needs and for his steadfast courage and resolute determination in promoting the programs in Public Health to meet these needs.

WIN PUBLIC HEALTH SERVICES AWARDS

A highlight of the N. C. Public Health Association's banquet was the presentation of annual awards for outstanding service in the field. Winners, from the left, are Dr. E. H. Ellinwood of Greensboro, Mrs. J. B. Spilman of Greenville, Mrs. Pauline J. Bateman of Tyrrell County, Dr. Mary B. H. Michal of Boone, and State Senator Julian R. Allsbrook of Roanoke Rapids.



1965 Recipients of 25 Year Awards

Mrs. Pauline J. Bateman, Public Health Nurse, Tyrrell County Health Department, Columbia,

Mrs. Rosamond N. Brock, Public Health Nurse, Duplin County Health Department, Kenansville.

Mrs. Ruby B. Bryson, Public Health Nurse, Haywood County Health Department, Waynesville.

Miss Delnoy Burrus, Clerk, Dare County Health Department, Manteo.

Dr. John S. Chamblee, Health Director, Nash-Edgecombe-Rocky Mount District, Nashville.

Mrs. Lillian M. Deal, Clerk, Burke County Health Department, Morganton.

Mrs. Evelyn H. Dudley, Public Health Nurse, Durham County Health Department, Durham.

Mrs. Ruth G. Harris, Public Health Nurse, Forsyth County Health Department, Winston-Salem.

Mr. R. Frank Hill, Western District Engi-

neer, State Board of Health, McIntyre Building, Asheville.

Miss Pauline Neal, Public Health Nurse, Davidson County Health Department, Lexington.

Dr. J. W. R. Norton, State Health Director.

Mrs. Cleo G. Osborne, Public Health Nurse, Guilford County Health Department, Greensboro.

Miss Helen G. Trexler, Nurse, recently retired from service with the State Commission for the Blind, Box 494, Salisbury.

Mr. Ira E. Verble, Registered Sanitarian, Mecklenburg County Health Department, Charlotte.

Miss Hazel C. Wilfong, Public Health Nurse, Catawba County Health Department, Newton.

Mrs. Kate W. Williamson, Public Health Nurse, Cumberland County Health Department, Fayetteville.

Dr. John J. Wright, Director of Continued Education Series School of Public Health.



SYMPOSIUM GUESTS

An interesting symposium was one of the features of the NCPHA Annual Meeting. The panel, as shown here, discussed the Appalachian Regional Development Program and the National Environmental Health Sciences Center. Those pictured from left to right are Dr. Jacob Koomen, Jr., Assistant State Health Director, Raleigh; Dr. Robert Wilson, Professor, Epidemiology Department, School of Public Health, UNC-Chapel Hill; Dr. A. L. Finkner, System Radiation Department, Research Triangle; Emil T. Chanlett, Professor, Sanitary Engineering, School of Public Health, UNC, Chapel Hill; and John Hampton, Coordinator, State Planning Task Force, Raleigh.

Ninth Annual Occupational Health Conference Set for Charlotte

Governor Dan K. Moore will make the opening address at the Ninth Occupational Health Conference on Tuesday, November 9 at a banquet set for seven o'clock at the Queen Charlotte Hotel. Three hundred and fifty industrialists and physicians and their wives are expected to be on hand to greet Governor Moore and Mrs. Moore.

This will mark the third time the state's chief executive has addressed this work-health conference held annually in Charlotte since 1957. Governor Moore has been preceded by Governor Luther Hodges in 1958 and Governor Terry Sanford in 1963.

An award, to be presented this year for the first time, will be given to the Charlotte area firm having the outstanding occupational health program for both employees and executives. All entries must be submitted to the offices of Heart Services of Charlotte and Mecklenburg by October 1. Presentation of the award will be made at the

banquet by Brodie S. Griffith, President of the Charlotte Chamber of Commerce.

The Conference will continue with a day-long session Wednesday during which a dozen speakers and panelists will explore the Conference theme of "How to Cut Costs and Increase Profits—The Dollars and Sense of Occupational Health."

Speakers include Dr. Dan J. Moffie of the School of Business Administration, UNC-Chapel Hill; Dr. Howard Hess, Psychiatric Consultant, New York Times, New York; Dr. Menard Gertler, Medical Director, Sinclair Oil Company, New York; Dr. T. A. Lincoln, Oak Ridge National Laboratory at Oak Ridge Tennessee; and Dr. B. W. Goodman, General Electric Company, Hickory, N. C.

Panelists include James Simmons, management consultant, Rohrer, Hibler and Replogle, Charlotte, N. C.; Dr. William C. Matthews, Charlotte, N. C.; Dr. P. M. Dunning, E. I. duPont de Nemours, Kinston, N. C.; Dr. William B. Townsend, Humble Oil Company, New Orleans Mrs. Bessie Mae Snoddy, Belk Brothers Company, Charlotte; and Mrs. Geraldine O'Neal of Klopman Mills, Rockingham, N. C.

George W. Dowdy is chairman of the Greater Charlotte Occupational Health Council which is jointly sponsoring the two-day Conference this year with the N. C. Governor's Council on Occupational Health, headed by Fred E. Henderson of Winston-Salem, retired Western Electric executive.

Co-chairmen of arrangements are Mrs. William Scoggin, Executive Director of Heart Services, parent of the Charlotte Occupational Health Council, and Dr. William P. Richardson, Professor of Preventive Medicine at the University of North Carolina at Chapel Hill. Registration fee for the Conference is twelve dollars for the two days or seven dollars for either day.

Re-training Older Workers

An appeal to the states to develop re-training programs for older workers and an offer of assistance in the establishment of such programs has been sent the Governors of all states by the National Council On the Aging.

Edwin F. Shelley, NCOA vice president and chairman of its Committee on Employment and Retirement, in the letter to the state executives, called attention to the development of new programs and techniques designed to help middle-aged and older workers compete in the labor force.

"These new approaches might assist your state employment service, in cooperation with your state agency on aging, to develop further their services for workers 45-65 years of age," he said.

Methods and materials developed by the National Council On the Aging, the Office of Manpower, Automation and Training and the U. S. Employment Service are available, the letter noted.

"The National Council On the Aging will be glad to assist you", it added.

Shelley pointed out that "In 1964, workers aged 45 and over made up 39% of the civilian labor force, 46%

of the long-term unemployed, and only 11% of trainees under the Manpower Development and Training Act. This too-young-to-retire group aged 45-65 is not organized and has no spokesman.

"Too often it appears that local employment service staff assume employers are not interested in hiring older workers. On this premise, they may not be encouraging older job seekers to enroll in available training courses. But, the fact is that many older workers have been re-trained and then have been placed on jobs which utilize their newly acquired skills and knowledge.

"Federal policy clearly recognizes the need for re-training programs for the unemployed and under-employed, including older workers. The federal government, of course, cannot and should not mandate State action.

"State initiative and drive are keys to successful re-training and job placement programs for older workers."

The National Council On the Aging is a nonprogrift leadership organization highlighting the needs of older people. NCOA serves as a national, central resource for planning, research, consultation and materials in the area of housing, health, employment and retirement.

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THE HOSPITAL INSURANCE BENEFIT PROGRAM

THE 1965 social security amendments established a broad program of health insurance, known popularly as "Medicare", for people 65 or older.

The following brief listing of the basic provisions of medicare was supplied by Mr. Clay Stone of the Raleigh District Office of the Social Security Administration:

The 1965 social security amendments established two kinds of health insurance for people 65 or older—a Hospital Insurance Program and a Supplementary Medical Insurance Program.

The Hospital Insurance part of the program covers nearly every American 65 or over (except for certain Federal employees and certain aliens).

1. Except for the first \$40, it pays for covered hospital services up to 60 days in a participating hospital during a spell of illness. It also pays for all but \$10 daily for covered services for an additional 30 days of care.

2. It will pay 80 percent of the cost of diagnostic services received as an out-patient of participating hospitals during a 20-day period, except for the first \$20 each period.

3. It will pay post-hospital extended care in a facility which qualifies (after hospitalization of at least 3 days) for 20 days during a spell of illness. An additional 80 days is provided with patient paying \$5 daily.

4. It pays certain post-hospital home health care services furnished under an approved plan. This includes up to 100 visits during the year following hospitalization of 3 or more days. Services of visiting nurses, physical therapists, and other health workers (excluding doctors) are covered. Effective date of this program is July 1, 1966, except for post-hospital extended care benefits which start January 1, 1967.

The Supplementary Medical Insurance Program provides for paying doctor bills and certain other medical bills. Persons wishing this coverage must enroll and pay a \$3 monthly premium. It pays 80 percent of reasonable charges for covered services except for the first \$50 in a calendar year.

1. It covers physicians' and surgeons' services, no matter where received.

2. It covers up to 100 home health visits under an approved plan, in addition to those covered under the Hospital Insurance Program.

3. It includes certain other medical and health services, regardless of where rendered: diagnostic test; x-ray or radium treatments; surgical dressings, splints, casts; certain ambulance services; braces, artificial legs, arms, and eyes; rental of medical equipment such as iron lung; and many other medical items and services.

The Supplementary plan becomes effective July 1, 1966. It will not pay for any goods or services received before July, 1966.

A leaflet "Health Insurance for the Aged" describes provisions of medicare more fully and is available without charge at your local Social Security office. You may write or call your local Social Security office for a copy.

In this state, the State Board of Health has been designated by Governor Dan K. Moore to administer the state-related functions of the Medicare program. The Board of Health will be responsible for certifying hospitals, nursing homes, and some health programs meeting Federal standards. It will also provide consultation and assistance in setting up staff committees in each institution to review the quality of care and the length of stay of patients and will advise institutions how to participate in the Medicare program.

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DATES AND EVENTS

October 19-22 — American Dietetic Association, Cleveland, Ohio.
October 21-23 — National Council on Family Relations, Park Plaza Hotel, Toronto, Ont.
October 21-23 — NC Orthopedic Association Convention, Wrightsville Beach.
October 23-24 — NC Division, American Cancer Society Convention, Raleigh.
October 23-28—Annual Meeting, American Academy of Pediatrics, Chicago, Illinois.
October 26 — American Association of Poison Control Centers, New York, New York.
October 26-29 — Annual Meeting, N. C. State Nurses' Association, Jack Tar Hotel, Durham.
October 27-29 — American Cancer Society, New York, N. Y.
October 28 - Nov. 5 — American Occupational Therapy Association, Miami Beach, Fla.
October 29 - Nov. 2 — American Heart Association, Miami Beach, Fla.
October 30-November 3 — NC Optometrists Society Convention, Charlotte.
November 4-6 — 38th Annual Meeting, NC Home Economics Association, Charlotte.

November 5-6 — Annual Meeting, NC Pediatric Society, Mid Pines, Southern Pines.
November 6 — American Association of Public Health Dentists, Las Vegas, Nev.
November 7 — American College of Dentists, Las Vegas, Nev.
November 8-11 — American Dental Association, Las Vegas, Nev.
November 11-13 — Gerontological Society, Los Angeles, Calif.
November 16-18 — NC Recreational Conference, Charlotte.

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Focus on the Family

- The keynote address (page 2) at the recent Annual Conference of the N. C. Family Life Council. The speaker was Vladimir de Lissovoy, Ph.D., Associate Professor of Child Development and Family Relationships at the Pennsylvania State University.
- Also comments on courses in Marriage and Sex Counseling for medical students at Bowman Gray Medical School of Winston-Salem, N. C., and elsewhere. (Page 13.)



Dimensions of Family Life Education

Keynote address at the annual conference of the N. C. Family Life Council held in Charlotte in October, 1965.



**by Vladimir de Lissovoy, Ph.D.
Associate Professor of Child Development and Family Relationships, Pennsylvania State University.**

Introduction

MANY "years" ago, last March 22d to be exact, your gracious Program Chairman invited me to appear before you as the keynote speaker. The very thought of coming before this distinguished Family Life Council was most disturbing yet somehow in a moment of delusions of grandeur I accepted.

I assure you that I am here with humble heart for this is a Council of outstanding reputation and you have heard, before this morning, some of the most distinguished men and women of our country in the area of family life.

My task was not made lighter when I stopped to consider some of the stellar talent within your Council; indeed many of your members I hold in great esteem and I have been inspired by their words and researches. As I formulated my thoughts for this presentation I began to have serious doubts as to what I could add to the wisdom already repositied in your Council; North Carolina is replete with talent of the past and present.

This is the former home of Gladys & Ernest Groves and Reuben Hill; your Council can boast of one of the outstanding presidents of the National Council on Family Relations in Clark Vincent; national leaders in teaching and research seem to have found a haven in your state. Ethel Nash, Bill Sperry, Frances Jordan, the beloved Mildred Morgan, Naomi Albanese, Kate Garner, Charles Bowerman, Dr. Frank Lock and on and on.

You see, I come to you knowing full well my limitations and I am honored for this opportunity to bask in the reflected glory of this Council and its illustrious membership.

I have been in the field for a long,

long time and sometimes I find myself discouraged by the seemingly repetitive themes, oft quoted generalizations, and the quibbling over definitions. I am tempted to say "Let's get on with the job," but I am reminded by more tolerant colleagues that the concept of family life education is still relatively new and that I am quite presumptuous in wanting to "get on with the job" without really knowing what the job is.

In the next few minutes I want to share with you some of my ideas regarding the "Dimensions of Education for Family Living." Your Program Chairman, Mrs. Rich, was good enough to pose some rather definite questions but I am hoping that she lost the carbon of that correspondence and I count on her "Southern hospitality" to let me beg a few of her most penetrating queries.

Family a Cultural Universal

We are told by anthropologists that **family** is a cultural universal. In all known cultures a small group binds itself to perform the tasks of reproduction, sexuality, economic sustenance and socialization of the children. It is true that the structure of the family may vary from group to group but generally the functions embrace those mentioned.

We also know that families form a basis of the body politic of a larger group, the tribe, or in more sophisticated civilizations, the nation. Long before the scholarly analyses of social scientists folk wisdom noted the importance of families. Your past-president, Elizabeth Middleton, quotes a Chinese proverb to illustrate this:

"If there is harmony in the home,
there will be order in the nation;
If there is order in the nation, there
will be peace in the world."

The lessons of history have shown to us that families withstand wars and

revolutions, pestilence and disease and still manage to survive. Planned destruction of families have failed as can be noted in the Russian post-revolutionary planning.

In the communist China of to-day the family is at a low ebb but still surviving. Ping-Ti Ho, renowned expert on early modern and modern Chinese history concludes that, in spite of the hardships imposed upon the traditional Chinese family system, the function of procreation, nurturance and education of children with love and understanding is still being carried out by the family—all of this "under circumstances many times more difficult than those which confront the Western family." He concludes "the family will survive."

(Ho, Ping-Ti, "An Historian's View of the Chinese Family's System," in Farber, S. M. et al, *Man and Civilization*, The Family's Search for Survival. N. Y. McGraw Hill 1965 pp. 15-29)

The tenacity of the social organization we call family in its capacity to survive is no less a miracle than the evolution of the hominids and the unity of mankind may yet resolve itself in the values and strivings common to all families. Perhaps this is the ultimate answer to the quest for peace—not government to government but family to family.

Let me illustrate this by reading to you an excerpt by a "family life specialist" from a country that is our official "public enemy number one." Makarenko is the "Spock" of the Soviet Union. He is characterized by the Maces as "the friend, philosopher, and guide of Soviet parents." (p. 277) Here Makarenko lectures on the importance of parental behavior, (translation by the author) p. 354

". . . Do not think that you are influencing the child only then when

you talk with him or when you are teaching or directing him. You are educating him at each moment of your life even during your absence. Your manner of dress, the way you speak to others and how you speak about other people, how you express happiness or sadness, your treatment of friends and enemies, how you laugh, how you read the newspaper—all of these things have a significant effect upon the child. The child is aware of the slightest change of tone, the changes in your thoughts reach him by imperceptible means even though you yourself may not be aware of these changes. And if at home you are impolite, or a braggart, or drunk and even worse if you insult the mother, you then have no need to think of proper upbringing for children: you are already doing a poor job of it and the best of advice or methods won't help you.

"Parental self-discipline, parental

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respect for one's family, parental self-control of each action—this is the first and the most important method of bringing up children."

Many of us would consider this a bit of an over-dedication but it serves to illustrate my point—this could have been a sermon in Iowa.

Traditional Comments

On January 25-26 1964, a symposium was held in the series of "Man and Civilization" at the University of California in San Francisco. Illustrious scientists and educators were called together to focus upon the American family. The discussion noted the strains and discontinuities in current family life (as noted in divorce, crime, violence) but the essence of the prevailing opinion can best be generalized by a quote from the presentation of James A. Peterson of the University of Southern California,

"The American family may be struggling for survival, but it is a vigorous struggle, and it is being waged on many fronts. It may very well turn out that our definition of the struggle may be in error—that what we are really about is the birth struggle of a new and vigorous family system." p. 79

Be this a birth struggle or the effect of cultural lag many of us are confident that man has the will and even the power to improve his lot. Your presence at this council attests to this.

Dimension of Family Life Education

In the examination of literature on family life education I counted no less than fifty articles on this topic in the various professional and semi-popular journals. The field is replete with examples of courses of study, bibliographies and evaluations. Much of the writing is repetitious, impressionistic and defensive. Early essays dealt with "family life" in an idealistic ethico-religious manner; more current writing is based upon empirical knowledge

and stresses the values of family life education much more pragmatically. Some current ideas, especially in the area of sexual behavior, suggest a primacy of biological drives but even these are tempered with recognition of the importance of individual values and evaluation of ego strength.

Much evidence is available that family life education is a recognized area of human concern and with the current Federal and State emphasis on human services it will be increasingly more important. For the purpose of this discussion I take the definition of family life education given some years ago by Muriel Brown. She states,

. . . [Family life education] . . .

"that part of a total education which equips individuals for effective membership in the family so that each contributes to home and community life according to his capacity." (From Fishbein and Kennedy p. 19)

The dimensions I will discuss will be necessarily limited and I will confine my remarks to four social systems which I feel can and do contribute most this area of concern.

The School

No national studies of family life education are available but in a review of literature dealing with three state wide studies in the North Central United States, Bayer and Nye (1964) give the following generalizations:

1. "The greatest percentage of family life courses are offered in home economics and social studies.

2. "More girls than boys are enrolled in high school family life courses.

3. "Most family life courses are elective rather than required, and most are offered to both sexes.

4. "Most family life teachers are women, practically all are married and many have had college preparation in home economics.

5. "Areas involving marriage, dating and courtship receive the most attention in family life courses; sex education receives the least."

The authors conclude their survey of family life education by stating that the great majority of the teachers in this area are inadequately prepared to do a professional job and that, "It seems probable that such teaching is on about the "Ann Landers" level."

De Lissovoy and Hitchcock in a study of 647 public and private schools in Pennsylvania noted similar results. In the public schools the three departments offering family life education most often were Home Economics (125), Health & Physical Education (91) and Social Studies (55). While subject matter relating to family living was covered in a variety of classes, specific courses entitled Family Living or a similar designation were offered in only 83 schools.

To sum up the Pennsylvania Study, 69% of the schools claim to cover some subject matter in this area but only 18.6% offered courses entitled Family Living.

Findings from other studies show like trends. Sperry and Thompson in your state (1961) found that, "of the 611 principals who responded, 470, or more than three fourths reported that no family life education course, as such, was offered."

I know that I will not endear myself to some members of this audience when I say that in general we have done a pretty inadequate job of selling family life education to the public. There are many reasons for this but I will mention only a few hoping that subsequent discussion will contribute to this area.

First of all the climate of opinion generated in this country since the orbiting of Sputnik has created a re-

examination of our total educational effort. We have seen that our children are capable of greater scholarly productivity than was demanded from them in times past. Advances in the sciences, programs in new math, advanced placement tests and many other accomplishments attest to this. In order to keep abreast of changes teachers have gone back to school for more preparation, institutes abound, specialists have invaded the public schools. We have done very little to parallel this in our family life education area.

While not all of our youngsters will become astronauts, scientists, executives or even professional athletes, **the great majority will be married and will become parents.**

We need to do much to upgrade teachers in our area; only in one state is there required certification of family life educators and there are very few centers where first class training in the various social and behavioral sciences oriented to family living can be obtained. We have no business incorporating family life education into the curriculum unless the subject matter is based upon a solid foundation of knowledge, based on theory and research.

My colleague, Professor Broderick (1964), suggests three basic points in this matter, he feels that students should be offered,

1. "Information based on reliable research will augment their own experience.

2. "Concepts according to which they can analyze and interpret both their own experience and the newly learned information. and

3. "Opportunities to apply this information and these concepts to their own situation."

(MF, 26, 1 May 1964)

A second reason why I feel that we have not done as well as we could do is that too often we have been guilty of

giving the impression that what we really deal with is sex education.

Certainly we need to have adequate education in this area but sex education is **not** family life education.

I might add that **health education** is not family life education.

Too often parents and teachers get the impression that "getting ready for a date" or "to kiss or not to kiss" is family life education and too often, I am chagrined to say, the emphasis of our courses in this area is just this limited.

The third point I would make in this regard is that we have been too modest of our accomplishments. In the May 1965 issue of the *Journal of Marriage and the Family*, Evelyn Duvall reviewed more than 80 studies dealing with the effectiveness of marriage courses. She concludes as follows:

"Marriage courses have been proven to be remarkably effective in all measures used to evaluate them to date. They have a unique role to play in (1) dispelling ignorance about love and sex, marriage and family relationships; (2) assisting young people emerging from their parental families to clarify their own senses of identity; and (3) providing valid conceptions of what to expect, with the attitudes and skills related to competence in marriage and family living." (MF 27, 2 May 1965 p. 184)

In the August 15, 1965 *New York Times* the education editor, Fred Hechinger, devoted major space with a formidable headline: **Now Schools Teach How to Buy**. Reporting on this with all the newsworthiness of **life on Mars** Hechinger noted the cooperation of James E. Mendenhall, director of education for Consumers Union.

"Dr. Mendenhall gave some basic reasons why he thought the schools have a special responsibility toward the education of consumers. Not only

are teen-agers themselves "active consumers" of considerable affluence and trend setting influence, but they are also bombarded with conflicting appeals and claims, prices and bargains. Moreover, many of these youths—especially those who do not go on to college—enter into marriage and family life immediately after school."

Now what I found especially significant in this article is the complete absence of the role that family life educators have been playing for years in consumer education. By all means we should applaud and encourage the belated entrance into this area by the Lincoln High School in Yonkers but we should also do some drum beating on our own accord since consumer education has been and is a very important part of any respectable family education program.

Courses in driver education are to be found in all high schools in Pennsylvania—this is directly translatable into dollars and cents in terms of insurance premiums. Perhaps we should direct some research in this area. Recently, addressing a Statewide Conference on Children Born Out of Wedlock, held in Pennsylvania, Clark Vincent stated,

"If each state were to take only five per cent of the funds allocated for problems attributed to the family and use that five per cent for establishing and upgrading family life education in a manner comparable to what has been done in the teaching of math and the basic sciences, it would amount to considerable savings.

(Report of the First State Wide Conference on Children Born Out of Wedlock—Penna. April 30, 1965)

I mentioned earlier that health education was **not** family life education. By this I do not mean that health is not

important in the area of family life, of course it is, but the two are not identical. Too often health classes degenerate into "organ recitals" with an overemphasis on mechanistic aspects of anatomy and physiology.

This is not only a personal criticism. Recently (April 1965) the Committee on Public Health of the New York Academy of Medicine deplored the state of health education in the public school systems. In its report it stated that sex education in schools consisted, ". . . mainly of depersonalized accounts of the physiology of sex and a combination of exhortation and admonition". Among the reasons for the inferior status of health education in the United States today the committee stressed the following:

"Health education has low prestige and is often made the responsibility of the athletic coach or physical training teacher."

And it stressed the urgent need to upgrade health education teachers.

Recently considerable attention has been given to the role of guidance departments in our public schools. Is guidance to be limited to "tests and measurements," college and vocational placement? If not, guidance counselors need considerably more preparation than they now get in the areas of sociology of the family, human development and adolescent sexuality.

The Church—Home and Community

Rather than to orient specifically to the dimensions of family life education in terms of the church, the home or community I will instead try to point up several issues which at present seem to merit the attention of Family Life Councils; it will be obvious that no one social institution can be solely concerned. If I were to stipulate the approach that I deemed most important I would stress adult education—be it in the church or under community aus-

pices.

The New Morality

Our kids are literally bombarded by sexual stimuli. There is no longer a question of sex education—rather what kind of education? Control by fear and by guilt is all but gone and with availability of birth control devices and the unrestricted privacy available to most young people the control of sexual impulses is now a question of personal morals. Recently there has emerged a trend of thought labeled "the new morality".

While this permeates a number of our society its greatest emphasis is in the area of sexual behavior. Probably the foremost exponent of this philosophy in the scientific world is Albert Ellis. In the more popular literature this philosophy is to be noted in the publication **Playboy**.

Essentially the central thesis of this point of view is that if one is true to himself, if one does not needlessly harm others (here Ellis uses Kant's categorical imperative) and if one utilizes the central concept of the "golden rule," then sexual behavior can be free of guilt and conflict. Thus, for example, **fornication** which in many states is a crime, if carried on by freely consenting adults in a discreet manner is not only harmless but can be beneficial.

The **Playboy** philosophy expounded by Heffner (the publisher), and this is an oversimplification but I feel that this is its essential, is to be noted in that Heffner "can see no logical justification for opposing (impersonal sex) unless it is irresponsible, exploitive, coercive or in some way hurts one of the individuals involved". (**Playboy** July 1965)

The application of this philosophy is to be noted in a column of the **Playboy** Advisor, here is an example.

"Nearly all the girls we date at

our Midwestern college are fine where the physical aspects of love are concerned, but they lack the brain power necessary to make stimulating parents on other levels. Although we place high value on sensual satisfaction, we feel there should be a sound intellectual relationship as well. Any suggestions?"

E. D. and J. D., Canton, Ohio
Playboy's answer:

"Since you'll never make your girls intellectual (if they lack the necessary intelligence), why don't you reverse your technique—and try to make intellectual girls."

The point I would stress here is that family life educators need to be aware of the **new morality**. Eminent men and women are now involved in these issues and the writings of Ellis, Stokes, Kirkendall, Harper and others should be known as well as those of the more conservative school. Our young people receive a heavy dose of **new morality**—only by knowing this direction of thought can we be of assistance to them.

It is not my job here today to make an issue of the **new morality** in terms of sexual behavior but in calling it to your attention I trust you will consider its dimensions in terms of family life education be it in the church, the home or the community.

But new morality is not limited only to the area of sexual behavior. This year America was shocked when it was faced with the Genovese Case and its implications. You will remember this was the case of a 28 year old New York woman fatally stabbed as she returned home from work while 38 people ignored her cries for help.

This case spurred an international conference at the University of Chicago in April 1965 to examine the entire question of social responsibility under the title, "The Good Samaritan and the

Bad, or the Law and Morality of Volunteering in Situations of Emergency and Peril, or the Failing to Do So". American law generally imposes no duty or penalties on the "bad samaritan" who ignores strangers in need. Have we ceased to be "our brothers' keeper?" As one wag put it in these days of so many organizations what we really need is a "Society to Watchout for Others".

In July of this year students at the University of Wisconsin Center for Racine participated in a conference on The New Morality. The interesting thing about this conference was that although it was expected that most of the discussion would be centered on sexual behavior such was not the case. The report regarding this conference in part stated:

"The students concentrated less on the sexual aspects of the new moral code than its implications on such matters as foreign policy, free speech and civil rights. They raised questions but got few answers. This, a conference sponsor said, was a reflection of the questioning nature of the new morality that must find its answers on an individual basis."

(N. Y. Times July 18, 1965)

Is morality a dimension of family life education? Whose responsibility? How does one inculcate morality in the world of rapid social change? These are not rhetorical questions for we are going to be faced with increasingly more difficult decisions in all areas of human living.

Let me give you a last example in this area. American biologists are faced with the mounting possibility that they will soon be able to wield genetic factors to control bodily development in humans. Genetic engineering is very close to being a fact but biologists deplore the lack of any general gearing now to deal with the moral, legal and

sociological problems it is bound to trigger. To quote the Christian Science Monitor:

"As with the atomic bomb, they see this growing capability dawning on a world unready to face up to the responsibility of using it. Yet, they believe its long-range consequences will reach at least as far as the bomb's."

(C. S. Monitor, August 16, 1965)

Youth in the American Culture

Two favorite subjects of study among social scientists and popular writers are Women (their role, destiny, etc.) and Adolescents. Of late women had to take a rear seat so to speak but for some time now the adolescent has dominated the scene as the subject of commentary, criticism and concern. As one regards the scene one is struck with the fact that somehow we have forgotten the principles of individual differences and that while our social scientists have been guilty of some broad generalizations (as for example statements that youth subculture is characterized by rebellion and rejection of values) our popular press has gone hog wild in stereotyping that period of life known as adolescence.

The July issue of **Esquire** purports to give away such secrets about adolescents "as they view God, Adults, Education, Death", their language is analyzed, where they go is scrutinized, what they eat is examined. Amid glib journalism and superficial generalizations with a liberal sprinkling of sex the picture is dismal indeed. It was a relief to read the following issue of **Esquire** to note the reactions of the young people. In general they felt that **Esquire's** analysis was trite and stupid. Undaunted **Esquire** in the September issue published an article entitled "Stealing Their Way Through College", here is an excerpt,

"Students steal in the Big Ten, they

steal in the Ivy League, they steal amid the corn, the wheat, under northern hardwoods, on the shores of both oceans and in the hills of Vermont. They steal, they pilfer, they shoplift, they snatch, they swipe . . ." (p.96)

There are many similar diatribes under the guise of scientific investigation such as **Sex and the College Girl** or magazine "exposes" like "Morals on the Campus." It would seem that popular writers have just discovered a difference between youth and adulthood.

That there will always be an inter-generational difference is a simple truism and I would urge that those people who work with youth read carefully Kingsley Davis' article "The Sociology of Parent Youth Conflict"—though this was written some thirty years ago its analysis of psychosocial dynamics remains a classic.

Many years ago Lewis Terman pointed out that happy families tend to perpetuate themselves. Parent models are important. But this does not mean that parents are to blame for all of the shortcomings of their children. Many factors play a role in the epigenesis of personality and we know enough not to be seduced by simple causations.

And yet there is evidence that there are tensions among our young people that should be of concern to us. The more rigorous demands of our educational systems has created a cleavage between the able and the less capable. Indeed Talcott Parsons suggests that,

". . . the very rise in general education standards makes the position of the relatively handicapped—whether by low IQ, lack of family support, or other factors—relatively **more** difficult. I suggest that this is a major factor in juvenile delinquency." (The Family's Search for Survival p. 47)

The esteemed Clinical Professor of Psychiatry at Columbia University, Nathaniel Ackerman suggests that the adolescents of our time are "hoisting distress signals." He feels that they want the rest of us to know that they are in trouble and he suggests the main trends of juvenile disturbance to be as follows:

1. "A tendency to antisocial behavior, as expressed particularly in acts of unprecedented violence.

2. "A revolution in sexual mores, shown in a tendency to promiscuity and perversion.

3. "A wave of contagion that makes an obsession of everything hot: hot jazz, hot dancing, hot rods—a compulsive quest for an ever-new kind of kick.

4. "A leaning toward overconformity with family and community, or with the peer group; closely associated, a trend toward static-mindedness, a loss of adventure, a loss of creative spark.

5. "A tendency toward withdrawal, toward a loss of hope and faith, toward disillusionment and despair, with progressive destruction of ideals.

6. "A failure on the part of the adolescent to harmonize his goals with those of family and society, a trend toward disorientation, confusion, and fragmentation of personal identity; finally, as a result of aggravated disorders of social adaptation, an increasing vulnerability of the adolescent toward emotional breakdown."

Ackerman goes on,

"The core of the problem is epitomized in the adolescent's fierce, often failing struggle to find himself in the near chaos of the contemporary world . . ."

and this should be of particular heed to those of us in family life education,

"Adolescent behavior needs to be

matched, particularly, against the turmoil and instability of marital partnerships, the insecurity of parents, and the disintegrative trends in family life as a whole . . . Not only are families confused, disoriented, fragmented, and alienated; whole communities often exhibit analogous trends . . ."

p. 90-91 of **Family's Search for Survival**

I quoted at length from Ackerman because his analysis poses such challenges to family life educators be they oriented to school, church or adult education.

Early Marriages

I need to say just a few words about early marriages. This is probably one of the most overdramatized subjects in the popular press and yet it does merit careful attention of family life educators. In fact the net rates of marriages under the age of 20 have remained constant for the last 10 to 15 years but there will undoubtedly be an increase in the number of marriages that will take place now that the youngsters born in 1946-47-48 are coming of age. Various assessments have shown that early marriages are more prone to failure than marriages that take place in their twenties. While it is important not to overgeneralize, it seems clear that "behind age at marriage are numerous confounding influences which increase the risks for achieving marital success at age 16 or 17 and possibly at age 18." (Burchinal MFL May 1965 p. 252)

It is estimated that divorce rates are approximately three times greater than those of couples married in their twenties. Premarital pregnancies range between 30-90% when both are of high school age. Much evidence exists to show that child care by young parents is often negligent and inadequate. Medical journals have noted an increased

number of "battered baby" syndrome in offsprings of the young parents.

In my own research I have found that youngsters who married while in high school are functioning as families against great odds. The school does not accept them and, in fact, we found that most school boards exhibit a punitive and discriminatory policy toward young marrieds. They are in debt and are usually recipients of some form of public assistance. Interestingly enough of the 48 couples I have studied intensely the great majority felt that they were "forced" into marriage by the fact of premarital pregnancy. Not one of the couples had an opportunity to explore their feelings in a counseling situation to see if they really **wanted** to get married.

I agree whole heartedly with Lee Burchinal who suggests,

"Programs to help youths avoid injudicious marriage decisions may well serve best by not focusing on the risks of youthful marriage per se, but instead, by assisting youths to develop their personalities, interests, and potentials as fully as possible. Socialization experiences in the home and community programs in schools, churches, and other organizations can play a part."

(MFL May 1965 p. 253)

I would make three succinct suggestions regarding early marriages.

1. I would urge communities to make a thorough study of school policies regarding married high school students. Such policies should be widely known and when students contemplate marriage I would urge that premarital counseling be made available to them.
2. Adult education in the area of pre-natal classes should encourage the enrollment of engaged couples regardless of age.
3. Community mental health agencies

should expand their efforts to encourage younger clientele. Here the "agency" might have to go out to the youngsters in cooperating programs of 4H, Hi-Y, young people's church groups and the like. Avenues of communication need be opened to young people so that counseling can be made available to those who need it.

In 1964 the National Council on Family Relations established a standing committee on Family Life Education. Its charge was to seek areas yet unexplored where family life education could make a contribution. To date we have only formulated tentative ideas and I will conclude with a simple enumeration of only a few ideas to suggest the dimensions of thought on the National Council level. ^

1. **Foster emphasis in family life education for high school guidance counselors in formal training and especially in the Institutes.**

2. **Establish liaison with organized labor to make available materials and resource personnel at the union local level.**

3. **Make available materials and resource personnel to the Armed Services. Educational advisors.**

4. **Establish methods of contribution to this area in "house organs" of large corporations.**

5. **Develop and implement family life education materials suitable for use in prison education programs.**

6. **Offer courses and programs to unwed mothers in the various types of confinement homes.**

7. **Develop programs especially oriented to low income families.**

It is hoped to refine these and many other ideas into workable projects for utilization by Regional, State and Community councils.

Sex Is Only Part Of It

by **Daniel L. Cheney**

In *SK&F Psychiatric Reporter*, Sept.-Oct.,
1965. Used by Permission.

Who advises most couples with sexual problems? Not psychiatrists. Not marriage counselors either. Almost all these couples go, at first anyway, to general practitioners or gynecologists, a good many of whom, by their own admission, have neither the skill nor training to handle these problems satisfactorily.

"Most doctors are not much better informed than the patients they counsel," according to psychiatrist Harold I. Lief, who places part of the blame for this inadequacy on the personality of the typical young man who studies medicine; conscientious, shy, restrained, obsessive-compulsive, perhaps sexually inhibited, whose defensive and moralistic attitude toward sex limits his understanding of, and rapport with, patients who come for advice about sexual matters.

Mrs. Ethel M. Nash, President-elect of the American Association of Marriage Counselors, agrees, at least in part, with Dr. Lief. She told me, "About-to-be-married couples expect the physician to give them information about such things as the orgasm, sexual techniques, frequency of intercourse, and methods of contraception. But a surprising number of physicians aren't capable of dealing comfortably with these subjects. Even those who **are**, often can't help the many people who really need information about love, not just sex. Sex is only part of it."

Mrs. Nash is one of two women who have pioneered in the organization of courses in marriage and sex counseling for medical students. The other is Emily H. Mudd, Ph.D., who was Executive Director of the Marriage Council of Philadelphia when, in 1950, it became part of the Department of Psychiatry at the University of Pennsylvania School of Medicine.

Five years later, **Mrs. Nash**, at the invitation of Dean Manson Meads, set up a similar yet more extensive course at **Bowman Gray Medical School in Winston-Salem, North Carolina**. Running through all four years of medical school, it is the only **required** course of its kind.

Both **Mrs. Nash** and Dr. Mudd, along with other experts, had been consulted

by the American College of Obstetricians and Gynecologists before it launched one of the most significant and far-reaching projects in its 14-year history. As an editor of **Consultant**, SK&F's magazine for family physicians, I had arrived at the College's 1964 meeting in search of appropriate material for that magazine. I stayed to witness what may be the beginning of a revolution in medical education, a revolution announced matter-of-factly by the College's President, Dr. Frank R. Lock, when he reported that the ACOG had decided to play the "leading role in initiating a national program for education of the medical profession in family life aspects of patient care."

To begin with, the ACOG set up a Liaison Committee that also includes representatives from three national organizations: The American Association of Marriage Counselors, the National Council of Family Relations (an organization of educators), and the Groves Conference (an organization for research). Plans are reportedly afoot to expand the Liaison Committee to include several other national medical organizations.

"It's the greatest thing that's ever

happened to the family life movement," **Mrs. Nash** said. "For the first time, a prestige group is solidly behind it."

But why should physicians be expected to take on a job that many, if not most, have neither the desire, training nor temperament to do well?

Dr. Lock had an answer to that: "Patients expect it. The widely held myth that physicians are sexually omniscient is one of the burdens of the profession."

And Dr. S. Leon Israel, Chairman of ACOG's Committee on Family Life Education, added, "Physicians routinely see patients at the logical times for counseling: girls at the menarche, engaged couples at the premarital examination, wives during pregnancy, the premarital examination, wives during pregnancy, and both husbands and wives when psychosomatic disorders should signal that the marriage relationship may be going wrong."

"So we're not urging physicians to take on new chores," **Mrs. Nash** said. "We've done surveys showing that 93 percent of GP's, internists, obstetricians, and gynecologists are already dealing with marital and sexual problems."

Physicians, then, are marriage coun-

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selors whether they want to be or not. They might like to pass on the counseling job to someone else—but to whom?

Mrs. Nash reported that a survey conducted in North Carolina revealed that almost 80 per cent of the physicians there rarely, if ever, refer patients to marriage counselors—simply because there are so few around.

Physicians are well aware of their own deficiencies. According to studies done by the ACOG, one out of every three feels he's **not** qualified to counsel patients, and over 90 per cent feel they need more training to do the job well.

Dr. Lock said, "Surprisingly enough, even among Fellows-elect of the ACOG, a good 40 per cent think they aren't sufficiently trained to counsel patients on sex and marriage."

Neither are some alleged marriage counselors. The supply of qualified counselors falls far short of the demand, and in most states inadequate licensing procedures have opened the door to people whose qualifications, to put it mildly, fall short of the mark. Last year, California, for example, passed a law licensing as marriage counselors anyone with the price of the fee and an M.A. in any behavioral science. Result: 1,000 licensed marriage counselors within three months. The American Association of Marriage Counselors lists 32 as qualified.

So, the ACOG reasons, if the average physician must take on other people's marriages "for better or worse," as it were, education will make him better. Nor should his education consist merely in learning the appropriate physiologic, psychologic, and sociologic facts and theories. He should also become trained in the technique of counseling. Dr. Mudd said, "In my opinion, even if a student becomes, say, a radiologist and never does any marriage counseling, training in the technique

will be helpful. Once he has learned to counsel patients on sex, he should find counseling them on less sensitive and complicated subjects relatively easy."

But—in the light of **Candy, Fanny Hill**, and the highly publicized "sexual revolution"—aren't most young people too sophisticated these days to need much instruction about sex? Besides, aren't there any number of inexpensive serious books on sex and marriage that go into the subject quite thoroughly—no holds barred, so to speak? Well, according to the experts, although the quantity of available published information is great, the quality of much of it is uncertain. They urge physicians never to take for granted that patients are adequately informed. Often, Dr. Israel pointed out, the problem is more one of countering misinformation than of supplying information. "Whatever knowledge possessed is often superficial," he said, "and, what is worse, it's colored by a belief in ancient, but persistent, taboos."

But even though young people need better information about sex, authorities agree that this is no longer their most important need. Some may know a great deal about sex, and nothing about love.

Mrs. Nash said, "This fact is of enormous significance to anyone who attempts to cure a sick marriage. I usually ask clients 'What is it that you want **for** your spouse?' You know, often that question leaves them speechless. The little word **for** throws them off balance. All they've been thinking about is what they want **from** their spouse."

Dr. Mudd said, "At the University of Pennsylvania we require students to observe a marriage counseling session through a one-way window. A unique experience for them. Usually they see only one member of a family and get only one side of the story.

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When they see the counselor interviewing the husband, they quickly sympathize with him since his wife sounds like a witch. Often they are surprised when the wife appears to be attractive and seems reasonable in her attitude toward the marriage problem. For the first time, some of them realize that marriage problems involve the interaction between two individuals, that it is what they are doing to each other that is important."

The chances are slim, Dr. Lock believes, that many other medical schools will institute required courses in family life education, but there are signs that more and more schools are recognizing the students' need to learn more about the field. Nearly all schools have been studying the ACOG recommendations for such courses, and a few offer a series of lectures on family counseling. If as seems possible, the ACOG's Liaison Committee expands to include other important medical organizations (the Association of American Medical Colleges, for example), its influence with medical school administrators will be greatly strengthened. The expansion would also facilitate the organization of postgraduate courses for practicing physicians. But the ACOG does not an-

ticipate quick results. "We have embarked on a program so broad," said Dr. Israel, "that we envision 25 years for its fruition." Daniel L. Cheney

DATES AND EVENTS

1965

- November 16-18—NC Recreational Conference, Charlotte.
- November 16-19—Conference of State & Territorial Health Officers, Washington, D. C.
- November 17-20—National Association for Mental Health, New York, N. Y.
- November 18-19—Commerce and Industry Show, Raleigh.
- November 19-22—National Society for Crippled Children and Adults, Palmer House, Chicago, Ill.
- November 29-30—National Social Welfare Assembly, New York, N. Y.
- November 30-December 1—Southeast Dairy Conference, Charlotte.
- November 30-December 3—14th Annual Association of Rehabilitation Centers Workshop, Hotel Knickerbocker, Chicago, Ill.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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NOV 26 1965

North Carolina's First Lady Receives

First 1965 Christmas Seals

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The 1965 Christmas Seal Campaign was officially launched in North Carolina when Mrs. Dan K. Moore, State Christmas Seal Chairman, received the first seals from Dr. D. Hilton Seals of Sylva, president of the North Carolina Tuberculosis Association. Looking on and wearing her grandmother's corsage of seals is a future "Miss Christmas Seals," three-year old Jeanelle. This vivacious Miss is the daughter of Mr. and Mrs. Edgar Hamilton, Jr., of Shelby. Mrs. Hamilton is Gov. and Mrs. Moore's only daughter. (See page 2 for Mrs. Moore's message.)



V. 80 #11

November, 1965

Message from

Mrs. Dan Moore

1965 State Christmas Seal Chairman

BECAUSE of the need for concentrated effort against tuberculosis and other respiratory diseases, I am happy to serve as 1965 State Christmas Seal Chairman for the North Carolina Tuberculosis Association. It would please me greatly if each local TB association would have its most successful campaign this year.

Tuberculosis has been known to man and dreaded by him for thousands of years. Since 1904, interested citizens, showing their concern, have formed groups to work for the prevention of tuberculosis and the promotion of health.

These groups, tuberculosis associations, are the people's organizations. They represent the people's fight against tuberculosis and other respiratory diseases, such as emphysema and chronic bronchitis.

Tuberculosis is still a problem. It is seen in the number of new cases occurring yearly, the number of people being hospitalized each year, and the number of people being treated at home on drugs. In 1964, tuberculosis struck down 1,345 North Carolinians with active disease. How many unsuspecting individuals were infected by these persons is not known.

Our Christmas Seal dollars will support national research and six research projects being conducted here in North Carolina. Our dollars will also support an intensive educational program, services to patients, and efforts to find unknown cases.

As your State Christmas Seal Chairman, I take this opportunity to remind you that the Christmas Seal Campaign is one event which offers everyone a chance to show that he cares. Through it, citizens from all walks of life can make a contribution toward common goals — victory over TB, and control of other respiratory diseases.



Tuberculosis

In

North

Carolina

by

William A. Smith, M.D.

Chief, Tuberculosis Section

N. C. State Board of Health

Dr. Smith outlines here the continuing program of State Government to combat tuberculosis.

I. GENERAL

During the past year the interest and activities of State, county and voluntary agencies toward tuberculosis control and eradication has greatly increased. Meetings, seminars and workshops sponsored by State and voluntary agencies throughout the State have been well attended. There has also been good attendance to out-of-state meetings by personnel across the State who are actively engaged in tuberculosis programs. The increased interest in tuberculosis control can be attributed largely to Tuberculosis Control Special Project Grants made possible by the United States Public Health Service and, also, through the new program conducted by the State Board of Health. The old program, which consisted largely of tuberculosis case finding through community wide and special chest X-ray surveys of the population, was revised in January, 1965.

II. SPECIAL PROJECTS

The Special Projects began in the five counties of Alamance, Forsyth, Guilford, Halifax and Rockingham during the fall of 1964 and early 1965. Beginning July 1, this year, Nash, Edgecombe, the City of Rocky Mount, Pitt, Bertie, Craven and Beaufort Counties were included. It is believed that Tuberculosis Special Projects will continue and it is hoped that other counties which have a tuberculosis problem can be included in the near future. The aim of Special Projects is to extend diagnostic and treatment services to patients who are not cared for in hospitals. These projects emphasize:

1. The improvement of services to the unhospitalized patient and their families. These services will include clinic, laboratory and public health nursing.

2. An increased effort to bring to prompt examination tuberculosis sus-

pects as well as all close contacts to newly reported cases.

3. The examination of household associates of those school children who show a reaction to the intradermal tuberculin test of 5 mm or over; school children who show a reaction of less than 5 mm should be periodically tested.

4. Establish a tuberculin testing program in schools particularly for 1st and 9th grade children.

5. Establish an organized program for isoniazid prophylaxis to prevent the serious complications of primary tuberculosis in young children.

As to isoniazid programs other than the program for young children, Furculow and Deuschle of the University of Kentucky Medical Center recently presented an article entitled "A Theoretical Basis for Tuberculosis Eradication" which recommended isoniazid prophylaxis in those persons who showed pronounced skin reactions and the treatment was based on age and sex of the individual. Numerous studies throughout the world have shown that there is a definite relation to the breaking down in tuberculosis and the tuberculin reaction; the larger the reaction the greater the risk of breaking down.

Additional investigation as to the value of isoniazid as prophylaxis was carried out by the Tuberculosis Program, United States Public Health Service and published in 1961. In this study isoniazid was given prophylactically for one year to household contacts of recently diagnosed tuberculosis cases. The study showed that this drug reduced the incidence of tuberculosis in household contacts by about 80% during the year the drug was administered. More than 50,000 persons participated in the study.¹

Indications for isoniazid prophylaxis according to the skin reaction and type

persons to be treated as recommended by Furculow and Deuschle are noted below:

1) All persons will be treated prophylactically who have a tuberculin reaction of 20 mm or more of induration to the intradermal test.²

2) All persons who have tuberculin reactions of 10-19 mm on the intradermal test will be treated with the exception of:

a) Non-contact children age 7-11 years.

b) Non-contact females aged over 35 years, unless diabetic, pregnant, silicotic or on steroid therapy.

Isoniazid prophylaxis is a distinct advance in tuberculosis control and should be considered in control programs.

III. REVISED CHEST X-RAY SURVEY PROGRAM

In addition to these control projects now being conducted in the one city and 11 counties, the Tuberculosis Sec-

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Vol. 80 November, 1965 No. 11

tion is conducting the following program in place of the old case finding program through chest X-ray surveys with mobile X-ray units.

1. Two mobile X-ray units have been converted into self-contained mobile X-ray clinics and these clinics are available to counties for the purpose of assisting in the back-log of X-ray activities and particularly in the chest X-ray of unhospitalized cases, suspects, contacts, tuberculin reactors, food handlers, school teachers, barbers and beauticians; any other persons carried on the tuberculosis register and any persons other than those named who require a health card.

2. A third unit is available to conduct special case finding programs among high incidence areas determined by the local health director, also, prison inmates as well as personnel; personnel and patients in State mental institutions and migrants.

These units have been in demand by counties and the schedule for their activities have been scheduled to include September, 1966.

3. Records Analyst

There is now a Records Analyst in the Section who is available to counties to assist in the setting up or improving the Tuberculosis Register. The Analyst will call on health departments at the request of the Health Director.

4. X-Ray Technician Consultant

There is also an X-ray Technician Consultant in the Section whose duties are to assist local health departments in evaluating their X-ray facilities, offer advice to local health departments concerning equipment; establish in-training workshops for X-ray technicians in local areas; coordinate supplementary X-ray services to those counties where the facilities are not available or are inadequate.

This Consultant will be available to counties on request to the Chief of

Section.

In addition to activities noted above, the organization of chest clinics with the cooperation of the State Sanatorium System has been proceeding and at this time 82 counties have regularly scheduled chest clinics either in the health department or in the immediate vicinity; the Cherokee Indian Reservation, the City of Reidsville, High Point and Rocky Mount have clinics independent of county clinics. In addition to these chest clinics attended by physicians, many health departments have regularly scheduled X-ray clinics. There are 12 counties in the State which do not have X-ray facilities. In addition to county clinics for outpatient treatment the Sanatorium System has sufficient hospital beds to hospitalize without delay all tuberculosis patients. The people of this State are well served by facilities for the treatment of tuberculosis.

IV. MORTALITY AND MORBIDITY

There has been a steady decrease in tuberculosis deaths in this State since 1915; the State became a member of the National Registration Area in 1914. In 1915 there were 3,710 deaths from tuberculosis and in 1964, 159. The population of the State in 1915 was 2,472,635 and had the same conditions prevailed in 1964 as in 1915 there would have been 7,223 deaths in 1964 and over 72,000 active cases. The anticipated number of deaths in 1970 is, 123, death rate per 100,000 persons 2.4, present rate 3.3. The low number of deaths is due to the more effective drugs since World War II as well as an improved economy and health education.

New cases, particularly adult active cases of the lung or the so-called "catching kind" have been about the same since 1961, namely 942 in 1961 and 943 in 1964. There has, however, been a decrease in all forms, active, that is those cases in which other parts of

the body other than the lungs are involved. This decrease is:

New Active Cases All Forms

1962	1,344
1963	1,386 (increase of 42 cases)
1964	1,282 (decrease of 104 cases and 62 cases under 1962)

The tuberculosis situation in an area is determined by the incidence of new active cases and not by the number of deaths. **The intermediate goal** for eliminating tuberculosis, according to the Arden House Conference in 1959 was:

"For the nation, a new active case rate, by 1970, of not more than 10 per 100,000 population."

The number of active cases all forms in North Carolina in 1964 was 1,282 or 26.9 per 100,000 population and with the slow annual decline it hardly seems possible that the rate will be 10 by 1970. It is estimated that in 1970 there will be 1,392 active cases all forms in the State or a rate of 27.5.

The anticipated rate for 1970 is based on past experience.

Another GOAL set by the Arden House Conference related to tuberculin testing. This GOAL has to do with the number of 14 year olds infected with the tubercle bacillus. The GOAL is:

"For the community, control of the spread of the infection to the point where not more than one per cent of the 14 year-olds react to tuberculin."

In the Pamlico County, North Carolina Tuberculin Testing Study 1956-1961 it was found that 9.6% of the white children 10-14 years of age and 18.2% of the Negro children of the same age group showed a positive tuberculin test. There are children in other areas in the State who show a lower skin reaction rate, but it is highly improbable that the GOAL of 1% in 14 year olds can be reached for some time.

The tuberculosis situation in this

State, in so far as the active adult reinfection lung type case is concerned, has shown no improvement and actually that type case is the important type to control. The policy of improving services to the unhospitalized case and others on the register with isoniazid prophylaxis appears to be the correct approach. It is certainly worthy of an extended trial.

V. TUBERCULOSIS CONTROL AND ERADICATION IN THE UNITED STATES: THE SEVEN POINT PROGRAM OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS.³

The American College of Chest Physicians at the annual meeting in New York in June, this year, submitted a seven point program for the control and eradication of tuberculosis. Among the important points in the program were:

a. Stress preventive measures such as:

(1) "Prevent (a) first infection, (b) reinfection and (c) advanced tuberculosis in those at risk by appropriate use of periodic tuberculin tests or chest X-rays as follows:

(a) "Prevent first infection (primary disease) in children by excluding tuberculosis among close associates (e.g. family, teachers and other school employees). This is the child centered program and first priority in the eradication program. Provide for periodic tuberculin testing of negative reactors, especially school children, and as a companion part of all immunization programs.

(b) "Prevent development of active clinical disease (**Endogenous reinfection**) tuberculin reactors or recent converters by chemoprophylaxis (e.g. children under 4 years of age and

others at special risk). Nineteen per cent of the population are tuberculin positive and three fourths of all new cases found each year develop in this group.

(c) "**Prevent advanced disease** by the early X-ray diagnosis of minimal tuberculosis and the prompt use of chemotherapy, (e.g. those receiving routine X-ray examination as tuberculin reactors, general hospital admissions and others). Three fourths of all new cases are in the advanced stages when discovered because these measures are not carried out.

b. "Provide **information** about tuberculosis; public awareness of the disease and community responsibility must be established. This includes an understanding of health services and motivation of the public to use them.

c. "**Find, report, register and follow** all tuberculosis patients and immediate contacts. Unhospitalized active cases and those inactive less than 5 years are a first priority in control. Tuberculin reactors at high risk and recent converters must be recognized as a priority in the eradication program. Tuberculin positive children of pre-school age and proven tuberculin converters among school children should be registered if possible.

d. "Provide for proper diagnosis, laboratory support, **treatment** and complete rehabilitation of all known tuberculosis patients as a public health measure.

e. "Tuberculosis must be recognized as our **number one** chronic infectious disease and given its share of attention in the current programs of the Federal Vaccination Act to prevent communicable diseases of childhood."

There has been an attempt in this article to explain the new tuberculosis programs for tuberculosis control and eradication which are being conducted by the State Board of Health and also to include recent advances in isoniazid prophylaxis. Also, a seven point program for tuberculosis control and eradication submitted by the American College of Chest Physicians.

REFERENCES

1. Tuberculosis Program, Public Health Service, United States Department of Health, Education and Welfare, September 1, 1961, Isoniazid Prophylaxis in Tuberculosis Control Programs.
2. Dr. Michael L. Furculow, Professor, and Dr. Kurt W. Deuschle, Professor and Chairman, Department of Community Medicine, University of Kentucky Medical Center, Lexington, Kentucky, "A Theoretical Basis for Tuberculosis Eradication," July, 1965.
3. Carl W. Tempel, M.D., Chairman, Tuberculosis Committee, A.C.C.P., 1963-1965, Webb-Waring Institute for Medical Research, Denver, Colorado. Presented at the annual meeting of the American College of Chest Physicians, New York City, June, 1965.

Significant alterations in emphasis have been made in the Tuberculosis Control Program of the State Board of Health during the past year. Measures are being taken to assure that the most modern case-finding techniques are being encouraged throughout the State.

In order to orient local health departments to this new emphasis, the State Board of Health is presenting three Tuberculosis Seminars, one in each area of the State, during the latter part of 1965.

A State Fair Exhibit

Many people who attended the North Carolina State Fair this year discovered a somewhat unusual exhibit. While wandering through the basement of the Dorton Arena, many Fair visitors found representatives of the State Board of Health and local health departments busy giving tetanus immunizations with a "Hypospray" jet injector gun.

The booth was under the joint sponsorship of the Communicable Disease Control Section, local health departments and the Rural Health Committee of the North Carolina State Medical Society. The demonstration was presented to stress the importance of protection against tetanus for every member of the family.

Physicians, local health directors, public health nurses, and personnel from the State Board of Health volunteered to administer the tetanus vaccine during the week. Free tetanus shots were offered to Fair visitors between the hours of 10:00 A.M. and 5:00 P.M. each day.

During the week approximately 1,000 immunizations were recorded. In addition, thousands of leaflets, badges, and Family Immunization Record Books were distributed. Public interest was high and many questions regarding immunizations and the jet injector gun were answered by the immunization team.



STATE HEALTH EXHIBITS

These three state health officials are shown viewing exhibits at the 54th annual meeting of the N. C. Public Health Association held at the Jack Tar Hotel in Durham. Left to right are Dr. W. Fred Mayes of Chapel Hill, dean of the School of Public Health at the University of North Carolina; Dr. Isa Grant of Elizabeth City, association president; and Dr. J. W. R. Norton of Raleigh, state health director.



Picture on Opposite Page

Seated: Left to Right: Mrs. Rosemary A. Perdue, Laboratory Division, State Board of Health; Mrs. Stephen Hayes, Immunization Activity Program, State Board of Health. Standing: Mrs. Anne F. Cain, Immunization Activity Program, State Board of Health; Dr. Ronald H. Levine, Chief, Communicable Disease Control Section; Dr. W. Burns Jones, Director, Division of Local Health; Mrs. Kathryn Burkheimer, Public Health Nurse, Durham County Health Department; Mrs. Sally Staunton, Public Health Nurse, Durham County Health Department; Mr. Henry B. Woodard, Project Coordinator, Immunization Activity Program.

North Carolina Is Indebted To This Public Health Pioneer

Dr. William Picard Jacocks, a public-health physician who had served with the Rockefeller Foundation in the West Indies, Ceylon, India, and the American South, died on February 17th in Windsor, North Carolina. He was 87 years old. In a professional career that

spanned three decades, primarily in foreign countries, Dr. Jacocks was active in the campaigns against hookworm then being waged throughout the world. He joined the Rockefeller Sanitary Commission in 1913 in his home state of North Carolina and later, after the Commission had been merged with The Rockefeller Foundation, he worked in Texas, Arkansas, and Tennessee, helping to organize county-wide treatment centers.

In 1915 he was sent to the West Indies with the Foundation's International Health Commission, and two years later was assigned to Ceylon, where hookworm had made severe inroads among the workers on the tea plantations. The systems he established there are still the basis for public health operations in Ceylon.

With the exception of a year in the Army Medical Corps in 1918 and three years at Johns Hopkins working on a doctorate in public health, which he received in 1925, Dr. Jacocks remained in the Far East until 1942. In 1929, in addition to his work in Ceylon, he undertook a public health program in Travancore, India, for the International Health Division, and in 1934 he became the IHD's regional director for India and Ceylon, a post he held until his retirement from the Foundation in 1942.

(The above information taken from ROCKEFELLER FOUNDATION STAFF NEWSLETTER March, 1965.)

Upon his retirement from the Rockefeller Commission he again joined the North Carolina State Board of Health, serving as Director of School Health 1942-45, and as Director of the Division of Nutrition 1945-48 until his second retirement from public health work in 1948.

He was survived by two sisters: Mrs. G. W. Capehart, Windsor, N. C., and Mrs. T. A. Smithwick, Raleigh, N. C.



Annual Meeting

North Carolina Health Council

Tuesday, December 7, 1965

Jack Tar Hotel, Durham

- 9:00 Registration — Mezzanine
- 10:00 **Outline of Public Law 89-97 — What It Is and What It Means**
Mr. James W. Murray, Atlanta, Ga.,
Regional Commissioner, Social Security Administration
- 10:40 **What PL89-97 Means to Hospitals**
Mr. Marion J. Foster, Executive Secretary,
N. C. Hospital Association, Raleigh
- 11:00 **What PL89-97 Means to the Practice of Medicine**
Edgar T. Beddingfield, M.D., Stantonsburg
- 11:20 **What PL89-97 Means to Nursing Homes**
Mr. Travis Tomlinson, N. C. Association of
Nursing Homes, Inc., Raleigh
- 11:40 Question and Answer Period
- 12:00 Luncheon
Discussion of "A Study of Visiting in North Carolina Hospitals"
James P. Harkness, Ph.D., N. C. Memorial Hospital, Chapel Hill
- 2:00 **Rehabilitation—in the Health Center and in the Home after Discharge**
Robert A. Gregg, M.D., Physical Medicine and Rehabilitation,
Duke University Medical Center, Durham
- 2:30 **Rehabilitation of Handicapped Youth in North Carolina**
Mr. Robert A. Lassiter, Director, Division of Vocational Rehabilitation,
Department of Public Instruction, Raleigh
- 3:00 **Accomplishments of the North Carolina Fund and Office of
Economic Opportunity Act**
Mr. George Esser, Executive Director, The North Carolina Fund, Durham
- 3:30-4:00 Business Session



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health



Reaching

"Hard-to-Reach"

Families

Letters Requesting July Issue of The Health Bulletin

We received over 100 requests from 35 states for the July issue of The Health Bulletin which featured an article entitled, "Reaching 'Hard to Reach' Families". The issue was commended in the bimonthly publication "Channels" of the National Public Relations Council of Health and Welfare Services.

- 18 requests from New York
- 9 Pennsylvania
- 8 California
- 7 Ohio
- 6 Massachusetts
- 5 Washington, D. C.
- 4 Illinois
- Missouri
- 3 Indiana
- Michigan
- New Jersey
- Ontario, Canada
- 2 Florida
- Georgia

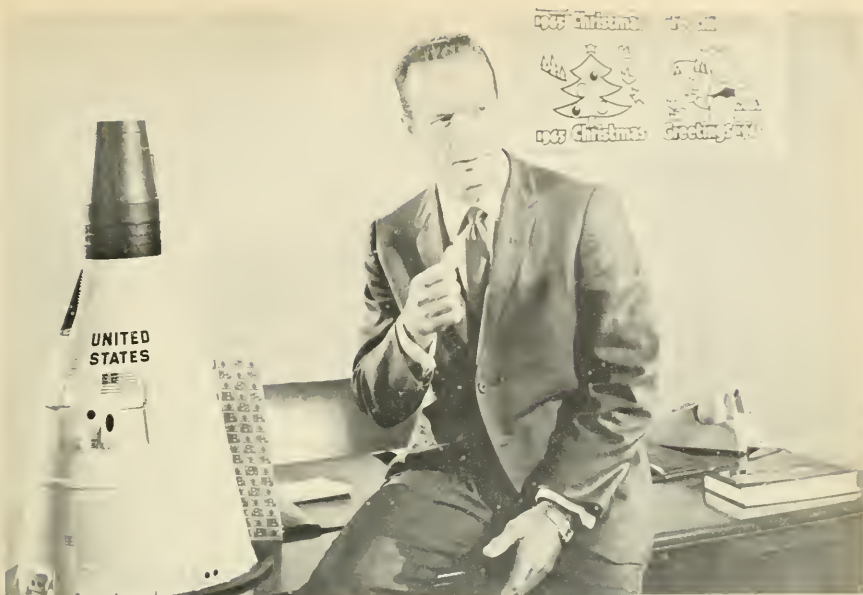
Iowa
Louisiana
North Carolina
Texas
Utah
Wisconsin

- 1 Alberta
- Arkansas
- Connecticut
- Halifax, Nova Scotia
- Hawaii
- Kansas
- Maine
- Minnesota
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Tennessee
- Vancouver, B. C.
- Washington

A Good Gift

Operation Santa Claus is the project of the North Carolina Mental Health Association. Each year this organization seeks to obtain at least one Christmas gift for each of the 15,000 patients and students in the State Hospitals and the Schools for the Retarded in North Carolina. All gifts must be new articles or gifts of money and must be delivered to the hospitals or schools by December 20th. Every cent of the cash donations in Operation Santa Claus will be spent only for patients' gifts. Eight institutions are involved. The address of the sponsoring Association is—N. C. Mental Health Association, Box 562, Greenville, N. C. Mrs. J. B. Spilman is the Association's Executive Director.

Statistics show that 550,000 Americans still die annually of heart attack. This is the greatest killer of business men in the most productive years of life, the North Carolina Heart Association says.



SCOTT CARPENTER

National Honorary Chairman - 1965 Christmas Seal Campaign

FACTS ABOUT CANKER SORES

An estimated 20 to 50 percent of the U.S. population is afflicted at some time during their lives with canker sores, painful recurrent ulcerations of the mouth, according to the U.S. Public Health Service.

A new booklet, prepared by the National Institute of Dental Research, discusses four types of oral ulcerations having a common characteristic—they recur at varying intervals during a person's life.

The most common—the fever blister or cold sore—may occur as infrequently as once a year, or as often as weekly or even daily. It is caused by the herpes simplex virus, or possibly several different viruses. The disease makes its first appearance in very young children—one to three years of age.

Single copies of "Canker Sores and Other Oral Ulcerations," (PHS Publication No. 1329) can be obtained without charge from the Public Health Service, Washington, D. C. 20201. The pamphlet may be purchased in quantity from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402, for 10 cents a copy or \$7.50 per hundred copies.

Revised Rules and Regulations Governing the Sanitation of Meat Markets, Abattoirs, Frozen Food Locker Plants and Poultry Processing Plants were adopted by the State Board of Health on December 3, 1964, and became effective July 1, 1965. These regulations are published separately as a supplement to THE HEALTH BULLETIN and are available upon request.

Convalescence Centers Planned by Holiday Inn Officials

By Lawrence O'Kane

A program for the construction of a national chain of convalescence centers has been announced by officials of one of the nation's largest motel chains, Holiday Inns of America.

The new medical centers, of which 400 are planned in the next few years, will be designed and built by a new company, Medicenters of America, Inc. Wallace E. Johnson, a builder of houses on a mass basis, and Kemmons Wilson, the two chief officials of the motor-hotel chain, will be chairman of the board and president, respectively of the new concern.

The centers will not be hospitals, nursing or rest homes, Mr. Johnson explained. Instead, they will be designed to fill the medical gap between intensive hospital treatment and a return to normal life.

So far, **one center is under construction in Columbia, S. C., and work is to begin on two others this month in two North Carolina cities, Wilmington and Gastonia, Mr. Johnson said.**

Model Center Planned

In addition, a three-story 150-patient center that will serve as a model and training school for the system is expected to be completed in Memphis early this year.

The company's timetable "calls for a minimum of 25 medicenters to be completed or in some stage of development within 12 months," Mr. Johnson said.

The announcement of the formation of the new company came four days after President Johnson signed the Medicare bill. The format of the new centers fits into the bill's provisions, which provide for up to 100-days of post-hospital care in an approved nurs-

ing home after an eligible patient has spent at least three days in a hospital. Under the law patients must contribute \$5 for each day in the nursing home after 20 days.

"Each Medicenter will care for 50 or more patients at approximate rates ranging from a **low of \$7.50 per day** [for indigent patients] to a "high of **\$15**, depending on type of accommodation and level of care," John A. DeCell, vice president of the new company, explained.

The convalescent centers will cost \$1 million to \$2 million each, depending on their size, a spokesman for the company said. They will be operated on a franchise basis, much like nationwide chains of roadside ice cream parlors or motor hotels.

Licensees will pay \$5,000 for permission to participate with a 50-bed convalescent home, or double that for a 100-bed home. They will also pay an annual percentage of the center's income.

Interest Expressed

The spokesman said that several large insurance companies had expressed interest in helping to finance the venture.

In recent years Mr. Johnson has opened and is operating convalescent centers in Memphis and Houston, as well as the 181-room Rosewood Memorial Hospital in Houston. Under the corporate name of Stewall, Inc., in association with Stewart Bainum of Washington, D. C., he also operates nursing homes in Cherry Hill, N. J., Richmond, Va., and Towson, Md.

Admissions and dispositions of patients will be under the control of attending physicians, Mr. DeCell said. In addition, free transportation will be provided between the centers and hospitals within a 15-mile radius.

From the New York Times, August 8, 1965.

To: Social Security Office—1122 Hillsboro St.—Raleigh, N. C.

HEALTH INSURANCE FOR THE AGED

The following person is 65 years old or older and is not drawing and has not applied for social security:

NAME _____ AGE _____

ADDRESS: _____

Phone No. where may be reached _____

(If completed by someone on behalf of the above person)

NAME _____

ADDRESS _____

PHONE _____

65 OR OLDER? HEALTH INSURANCE

Are you 65 years of age or older and have you applied for Health Insurance under Social Security? People who are drawing social security are automatically notified about the Health Insurance. There are, however, thousands of people over 65 who are not drawing social security, and these people must file an application for Health Insurance or "Medicare" as it is generally known.

If you are in this group or if you know of anyone in this group who has not been in touch with the Social Security Office, please fill out the following information and mail it to: Social Security Office, 1122 Hillsboro Street, Raleigh, N. C., Phone No. 828-9031, Ext. 466.

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DATES AND EVENTS

- Nov. 30 - Dec. 1—Southeast Dairy Conference, Charlotte.
- Nov. 30 - Dec. 3—14th Annual Association of Rehabilitation Centers Workshop, Hotel Knickerbocker, Chicago.
- Dec. 1-4—American Public Welfare Association, Chicago, Ill.
- Dec. 3-4—Association for Research in Nervous and Mental Diseases, New York, N. Y.
- Dec. 3-5—American Academy for Cerebral Palsy, Cleveland, Ohio.
- Dec. 6—Health Careers Seminars, Jack Tar Hotel, Durham.
- Dec. 7—Annual Meeting N. C. Health Council, Jack Tar Hotel, Durham
- Dec. 16—Tuberculosis Seminar, Hertford County Courthouse, Winton.
- 1966
- Jan. 25 — Tuberculosis Seminar, Kerr School, Clinton.
- Feb. 9-11—American Academy of Occupational Medicine, Philadelphia, Pa.
- Mar. 3-4—N. C. Mental Health Association, Annual Meeting, Queen Charlotte Hotel, Charlotte.
- Mar. 3-5—United Cerebral Palsy Association, New York, N. Y.
- May 1-7—Mental Health Week.

- May 6-7—Annual Convention, N. C. Licensed Practical Nurses' Association, Battery Park Hotel, Asheville
- May 18-19—17th Annual Meeting and Scientific Sessions, N. C. Heart Association, Jack Tar Hotel, Durham
- May 18-20 — Southern Branch, APHA, Shamrock-Hilton Hotel, Houston, Tex.
- May 29 -June 3—National Conference on Social Welfare, Annual Meeting, Conrad Hilton Hotel, Chicago, Ill.

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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A Prayer for Legislative Guidance

Special Session of The Senate
The General Assembly of North Carolina
Wednesday, November 17, 1965—9:30 a.m.

O Lord our God, how we yearn to be all wise that we might look into tomorrow and know the results of today's actions. How much easier it would be to make choices if the unknown were visible—but then, where would there be room for faith!

Restore our faith in the ultimate triumph of *Your Plan* for the world You have made.

May we be able to see through confusion and clouds caused by debate and find *Your Hand* pointing the way.

Give us grateful hearts for those who have walked this path before us—the founding fathers of our great State; the many who have sat in this Chamber enacting laws; and, not only those with whom we have agreed, but those with whom we have disagreed for they have caused us to consider more fully our own choices.

Thus, with an eagerness to do the right, this Body of public servants moves in faith to do that which It deems wise.

Guide them to this end, O Lord we pray.

AMEN

Russell B. Fleming, Chaplain

The Key That Christmas Gives

We will not have a star in the sky to light our ways to a manger, to a Babe wrapped in swaddling clothes — this Christmas Eve.

We will not run from the warmth and comfort of our homes into the darkness of the night to gaze in awe upon a midnight sky and hear an angel chorus sing.

We will have our church services, our paper and cardboard stables, our Bible, our gifts to loved ones, our gaily decorated trees — good things to eat — "Joy to the World" echoing above the sounds of battle . . . and we will have time . . . time for thought and for meditation.

We will have our deepened faith that comes with the Season . . . and our pleasant weakness, following after a year filled with trials and tribulations—and too soon to end.

We will have good will to all men, not just good will to some men.

We will be casting smiles to strangers on the street and wishing them well — the same smiles and well wishes we have too often reserved for a chosen few.

We will be preparing ourselves to mount the steed of hope to gallop forth into a New Year, with a bridle of faith to steer the beast to the furthestest star.

We will speak with reverence of God and Love.

We will be better people — for awhile — having within us what we term to be the "Christmas Spirit".

If each of us would be as he is in this, the Christmas Season, I wonder . . .
would we not possess the key to the door marked
"PEACE FOR MANKIND"?

Joyce A. Mills
Sanitary Engineering Division
N. C. State Board of Health

Christmas 1965



Biblical Recorder

Editor

Named State

Chairman 1966

March of Dimes

J. Marse Grant of Raleigh, editor of the Biblical Recorder, has been named state chairman of the 1966 March of Dimes for the second straight year, it was announced by Basil O'Connor, president of The National Foundation—March of Dimes.

Grant, father of a physically handicapped child himself, will lead in the organization and direction of thousands of volunteers throughout the state in the traditional January campaign to raise funds to fight birth defects.

"Birth defects are the nation's second greatest destroyer of life," the Baptist editor said. "Every year we lose half a million unborn babies as well as 60,000 infants, children and adults because of birth defects."

The state chairman said the work of the March of Dimes Birth Defects Center at Memorial Hospital, Chapel Hill, "is an example of what can be done. You need only to talk to the medical staffs in any hospital to recognize that we are scarcely scratching the surface of the problem. In our state alone, there are an estimated 7,700 babies born each year with birth defects. Throughout the nation, the total is more than 250,000. Although there are 57 Birth Defects Centers in America, twice that number are needed."



The Health Bulletin

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Vol. 80 December, 1965 No. 12

Christmas Comes But Once a Year

FOR SOME, THAT'S NOT ENOUGH . . .

Children—If Christmas came every day, then children would want it twice a day. The Christmas tree symbolizes the most magical days of childhood. No matter how long you leave it up, they'll still say, "Aw, do we have to take it down already?"

Parents—Yes, the bank account dwindles, and the crowds are exhausting, and you sigh that you're glad it's over with. But you know in your heart that memories are made of Christmas and children. There are other holidays but somehow they just don't give you that warm once-a-year glow called "the Christmas spirit".

Merchants—They would like to have Christmas business every day. But despite all the criticism of how commercial Christmas has become nowadays, what would Christmas be without the enchanting store windows, candy cane street lights, and the strains of "Jingle Bells" as you shop?

FOR OTHERS, IT'S ALMOST TOO OFTEN . . .

Health and Safety officials—To them the Christmas season is often a deadly season. Every year the death toll from accidents is a shocking contradiction of the spirit of a holy season. Children get killed by the very presents intended to bring happiness; sometimes whole families get killed on the way to a family Christmas. Homes are destroyed by fire and sometimes two or three family members perish.

Police—They're closer to the scene of tragedy than anyone else. They patrol the roads and arrest as many reckless and intoxicated drivers as they see. They clear wrecked cars off the road. They put bodies in ambulances. They make calls to victims' families. It's a bitter job anytime—but a lot harder on Christmas.

And perhaps some you know—Someone for whom Christmas is no longer happy because of a past holiday tragedy. For him or her, Christmas has lost its carefree happiness; New Year's, its bright promise. A loved one is gone; joyous laughter is stilled. A lot of people are glad that Christmas comes but once a year.

Christmas comes but once a year so keep it safe and full of cheer.

SIGNIFICANT POPULATION TRENDS IN NORTH CAROLINA

A Summary by Daniel O. Price

THE WHITE POPULATION OF THE STATE is increasing more rapidly than the Negro population with a resulting decline in proportion Negro.

The proportion of the population that is urban is increasing and will continue to increase, but Negroes are not concentrating in urban areas of North Carolina any more rapidly than are whites.

The proportion of females in the population is increasing, but the number of males at marriageable ages exceeds the number of females and is increasing.

The proportion of the population over 65 is increasing but at a higher rate for whites than for nonwhites.

The percent single is declining with almost everyone eventually getting married, but the proportion of broken marriages is increasing, especially among the nonwhite population in urban areas.

North Carolina has a slight loss of white population from migration but seems to have an increasingly large loss of Negro population due to net migration. The excess of births over deaths more than offsets the losses due to migration. Among the nonwhite population, out-migration seems to be increasingly selective of the better educated, especially among nonwhite males.

THE AVERAGE LEVELS OF EDUCATION in the State are improving but the level of education among whites is improving more rapidly than among Negroes. The educational level of Negro females is increasing more rapidly than that of Negro males.

INCOME LEVELS IN NORTH CAROLINA are continuing to improve but showing little gain relative to national income levels.

Average incomes in the rural areas of the State have not increased as rapidly as those in urban areas. The incomes of nonwhite males have not increased as rapidly as those of white males.

Incomes of nonwhite females have increased more rapidly than incomes of white females but are still only about two-thirds as high.

IF WE LOOK AT THE NUMBER of potential dependents per 100 people of labor force age we see that this figure is increasing in North Carolina as in the rest of the country. However, among nonwhites in North Carolina this dependency ratio is roughly 40 percent higher than for whites and increasing rapidly as a consequence of high birth rates and out-migration of young adults. This would indicate that there are tremendous economic advantages to be gained by individual families and the State from an expanded, state-wide family planning program that would insure that no woman need bear more children than she felt could be provided adequate opportunities by the family.

Institute for Research in Social Science
University of North Carolina
Chapel Hill, North Carolina

"All Mice Are Not Created Equal"

Although psychoanalytic theory holds that adult reaction to stress is determined by childhood experience, those of a hardier genetic strain may not be affected at all by early crises, according to findings of a study supported by a National Institute of Mental Health research grant.

The investigator, Dr. Benson E. Ginsburg, professor of biology at the University of Chicago, has found in his work with mice a strong relationship between heredity and certain facets of behavior, including some abnormal behavior under stress. He believes the same relationships may well hold true in people.

In Dr. Ginsburg's work, he subjected carefully bred mice to certain types of stress during infancy. Some of them, as adults, became significantly more aggressive than usual; others became less aggressive; others showed no effect. The results depended upon the strains to which the mice belonged—that is, upon heredity.

In other words, says Dr. Ginsburg, "All mice are not created equal."

The Ginsburg project and 19 other selected NIMH research studies in mental health are described in a new publication titled "Research Project Summaries, No. 2," issued by the Public Health Service of the U. S. Department of Health, Education, and Welfare.

Also included in the reports are studies on sleep; family communication as it relates to child development; brain waves and personality; drug tolerance; delinquent gangs; children of the rural South, and the brain's chemical coding systems, among others.

Scientists in the Public Health Service, U. S. Department of Health, Education, and Welfare, have shown that oysters and clams can quickly rid themselves of polio-virus and bacteria when transplanted from polluted water into clean water. This finding suggests that the shellfish may be "purified" before marketing, much as milk is made safer by pasteurization.

The Physician in Medicare

A subcommittee of seven physicians and two representatives of hospitals and Blue Cross met in November at Social Security Headquarters in Baltimore to continue discussions initiated last month on the role of the doctor in the new medicare program.

The group will consider draft policy recommendations covering the operation of hospital utilization committees.

Under the medicare program participating hospitals and other institutions will need to have utilization plans providing for the review of hospital stays by staff committees. Such committees must include at least two physicians.

The review will involve examinations of admissions, length of stay and the medical necessity of the services provided on a sample or other basis. "A major emphasis in this review can be statistical and should be directed to the promotion of efficient use of available facilities," said Arthur E. Hess, Director of Social Security's Bureau of Health Insurance to the group.

"The review," he said, "will focus attention on the appropriate type and level of care for the individual patient at each stage of his illness. The attending physician will, of course, be consulted on any decision affecting his patient."



Safety Zoo

A pamphlet in color (6"x9") emphasizing safety. Available upon request from the State Board of Health, P. O. Box 2091, Raleigh, N. C., 27608.

We are indebted to the staff of the McDowell County Health Department and particularly to Mrs. Marianna Stanley, public health nurse, for the original idea of this pamphlet. We also express appreciation to Miss Laura Breese, health educator in the Gaston County Health Department, for her most valuable assistance in this production.





Elephant in the middle of the road.



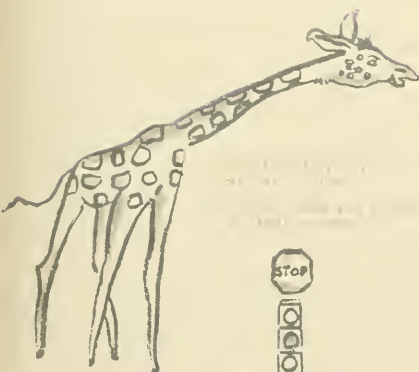
Kangaroo in the middle of the road.



Fox in the middle of the road.



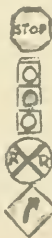
Lion in the middle of the road.



Giraffe in the middle of the road.



Bear in the middle of the road.



Presidential Address 1965 NCPHA

Ilsa C. Grant, M.D.

What are the ingredients of our public health identity? At our annual meeting in 1964 we had a panel whose title



was "Our Public Health Image", and Mr. Ed Rankin, our leader, pointed out that "identity" was a more powerful word than "image". This pro-

voke serious thought. It seems to me that our identity as public workers must be strengthened before we can render the service we wish to or obtain the necessary funds needed to function. As North Carolinians we must live the State motto—*Esse quam Videre*—"To be rather than to seem".

We must start by **knowing**. The best way knowledge can be obtained is by attending Schools of Public Health, but transplanting the knowledge into action comes only in our day to day work. We must "know" and since new knowledge becomes available daily in our rapidly developing world this is quite a task. Reasonable time in keeping up with our public health periodicals and meetings can also give us the asset. Knowing the sources of such knowledge and where the information can be found is part of it. The remainder is in the use of knowledge.

In applying this there must be a group that works directly with the people in regard to their health. One of such bits of wisdom was given to me by Dr. Hamilton, our former Chief of Laboratory Hygiene. He said "never

miss a meeting of your Medical Society". It seems he learned this early in his work in Wilmington when the Medical Society met and passed a resolution directly contrary to one the Board of Health had passed on milk. They did not have all the facts which Dr. Hamilton could easily have given them had he been there.

Another illustration that may be used is in nutrition. A teen-age group in Eastern North Carolina had had several discussions on vitamins and how they affected their lives. At the final meeting of the group the health educator was trying to help apply what they had learned to their daily diet. She asked them about the foods they themselves ate that contained these vitamins. No one could name back any food they ate which was rich in vitamin B. Only one boy raised his hand. He said all he could remember was that unpolished rice had high vitamin B content. His knowledge was correct but its application meant little to him unless it was used. In his community there was no unpolished rice.

Wisdom in public health is not just medical information but is a constant growing thing that includes such opportunities as in-service training, or that obtained from meetings and contact with one's fellow man. Dr. Spurgeon's words: "wisdom is the right use of knowledge. To know is not to be wise. Many men know a great deal, and are all the greater fools for it. There is no fool so great as a knowing fool. But to know how to use knowledge is to have wisdom".

For instance a nurse knows every old person needs rest and exercise and that a regime properly planned can make as much difference in that person's feelings and general health as any one factor. Ideally in her visit to the older person she should show them

**Edited slightly from address given at Durham NCPHA, 1965.*

simple exercises and discuss with them their pattern of rest. Since in most instances she calls for a specific reason this important part may be omitted. Many older people can't sleep late and so they arise early. Planning a place for them to take an afternoon nap and when they should take their daily walk can change their whole outlook because they feel better and all their bodily functions are more normal. A homemaker told me she never knew her husband should move around until the nurse showed her. She said her husband now slept well and looked forward to each day. That nurse's knowledge had been applied.

A sanitarian knows and preaches cleanliness. Yet the one that gets co-operation is the one that cleans the pipe fittings and hose in a complicated milk set up and thus illustrates to the dairyman where the dirt is. Telling him about it all may be imparting his knowledge but it shows no wisdom.

Close to the application of wisdom is work and labor. As Elbert Hubbard said "folks who never do any more than they get paid for never get paid for any more than they do".

Jeff of the cartoon characters Mutt and Jeff once made the statement that he did all the work he was paid for and then some. It's the "then some" that should make for merit raises and promotions. It's the "then some" that makes the sanitarian willing to visit restaurants at odd hours because its more suitable to the client, or the health director to make talks several nights in one week to acquaint the community with health problems, or the nurse on home care to go out week ends to relieve pain of the dying cancer patient.

As Bulver has said "what men want (or lack) is not talent, it is purpose", in other words, not the power to achieve but the will to labor. He be-

lieved that "labor judiciously and continuously applied becomes genius". This then is a way to gain the knowledge and wisdom we were talking about above.

Alexander the Great, reflecting on his friends degenerating into sloth and luxury told them it was a most slavish thing to luxuriate, and a most royal thing to labor.

In public health we have untold opportunities for work and labor. In fact there is so much to be done some must be left undone. The "then some" should include efficiency also. As Walter Dill Scott has said "it is more than probable that the average man could with no injury to his health increase his efficiency fifty percent". Think what it would mean to our public health if our work could be translated into fifty percent more service. Happiness in our work would doubly increase.

This brings us to the heart of our work and three things which should always be there. Truth of the public health principles we teach, and kindness and love in carrying them out. Truth is part of personal integrity.

As Emerson has said "nothing is at last sacred but the integrity of your own mind. Absolve you in yourself, and you shall have the suffrage of the world." In other words, if you have integrity it will be known and the vote will be for you. The word integrity comes from the Latin integer which means "untouched or whole". The public health worker should prepare himself to have this attribute and constantly strive to keep it bright and shining. Then he will have always a powerful tool in the "art of persuasion."

In relation to truth also is gossip which pretends to give extra vision but has all the "blindness of a bat." The gossip often talks himself into the belief that he is reporting the truth.

But since truth itself is frank most often reports of idle talk about office operations or why the health director changed such and such an item in the budget is reported inaccurately. Compare truth to the fragile head of a dandelion ready to spread its seeds in the first gentle wind. If it is plucked it is amazing if it keeps its parts until the bearer holds it to the level of his mouth. Then just a small puff scatters all seeds far and wide. To get them together again is all but impossible.

Actually the truth about what happens at the office is just about as difficult to hold together, and because idle talk can give only a small portion of the truth it fails to give the identity of public health and the poorest image of all—and it includes all members of the health team—and if mutual loyalty is not present gossip is easy and the public health identity completely clouded. An example is that of a secretary who says to all her friends that her "health director" does nothing each day but sit behind his desk and "read." In truth the health director may do that in his office. He gets enough information from the State Health Department and Public Health Service to keep all office time engaged in reading. But he may be at the same time meeting with several community groups and working with them on a total community plan and visiting clinics that will raise the medical care of the community.

Perhaps he is spending his time working on a new ordinance that will change the whole sanitation status of the community and yet he is so busy taking care of the many details he doesn't have time to keep his secretary abreast. The secretary sees him only the small part of the day he is in his office. Yet she or more often secretaries from other divisions report to their friends "the Health Director just reads", and

the community gets the idea that when people get tired of practicing medicine they retire into public health.

Every health worker should understand thoroughly the tremendous job for the good of health that is done through public health that no matter what the health department did it would exude this knowledge—and loyalty would thus be natural with them and the truth made beautiful.

Did you realize that the origin of the word "kind" from the Anglo Saxon is **natural**? This is the next part of love that I want to consider as a part of our public health identity. Wordsworth said, "the best portion of a good man's life is his little, nameless, unremembered acts of kindness and love."

All varieties of people visit health departments. No matter what his appearance, are we always as kind to them as we could be? Not always can the health department render the service they require, but always they can be kind in asking questions and giving complete directions to other places. Gentle inquiry as to how a person may be helped often is what gives the true feeling of what public health has to offer. For instance, a nurse can say "did you want something?" or "may I help you?" and there can be a tremendous amount of difference in the kindness contained in the two phrases.

Ask yourself if Dr. Palmquist, Director of Region III, U. S. Public Health Service, should appear at your front desk in hunting clothes or an unkept condition, would he receive the same kindness in directions as say, the chairman of the board of health?

Let us not then think of love as a simple attribute of public health. Indeed I like best D. H. Lawrence's definition "love is a thing to be **learned**. It is a difficult, complex maintenance of individual integrity throughout the

incalculable processes of inter-human polarity." In other words it contains integrity, loyalty, kindness in attitudes toward all people and caring for them.

One of our basic needs is to be needed and some of our happiest moments in public health work are those that come when we know we have fulfilled someone else's basic need. For instance a nurse visited in a family and noticed they are eating a diet of roast corn. She it is who asks the nutritionist to go with her and talk about basic food needs for growing children, and they listen to the nutritionist because they have sensed that the nurse "cared for them" and the nurse brought that other lady.

And sanitarians will recall that when they have worked with a restaurant owner about the need for new equipment, its advantages and disadvantages must be explained, but what really makes him make the change is frequently that the respect they have for the sanitarian himself.

When the public health worker and each of us has knowledge and wisdom, works and labors, and has integrity, kindness, and cares for the person with whom he is working, only then can we have the joy in our work that we deserve or the public health identity that inspires others to believe in us and support our programs wholeheartedly and monetarily.

Why then would we have used this time to talk about something you should already know. It is because we are not putting into action these basics and until we improve we cannot reflect the image we desire no matter how hard we try. And it's in the small daily action and utilization of time that this can be done. It is these little things that make for happiness: With apologies to "Peanuts" what is happiness?

A public health worker hears from

a builder that extensive restaurant repairs are being made because the public health worker informed the owner about the need.

A public health worker has a call from an eye doctor who tells her four of five patients she referred needed eye glasses and he thinks she is doing a marvelous job of screening them.

A public health worker is able to find a complete health record on a child who had not given correct name previously.

A public health worker discovers at a meeting a perfect audio-visual aid to illustrate something he knows is a local need and can bring back to his department.

A public health worker finds another health department following a suggestion of their's and profiting by it.

A public health worker hears himself introduced by a member of his board of health as the first person who has ever inspired him in public health work.

A public health worker has a mother confess to her she was afraid of her baby until the nurse showed her how to handle him.

A public health worker receives a letter from a tuberculosis patient who had been treated three years previously telling him that he remembers the advice the public health worker gave and is still living by it.

You may note that in giving this information on happiness no identification of the public health worker is made. This is because a togetherness deep within the public health commitment and spirit is what really drives it home and unless it is present identity cannot be reflected in the image. What is needed is "work done by a number of associates all subordinating personal prominence to the efficiency of the whole."

A public health educator said to me recently nurses and public health educators are always at odds yet each needs the other's help desperately. One must be developed personally in order to work together rather than to work individually. Each of you has the responsibility to the public health identity to develop yourself in this way. Respect and love for other workers is mandatory.

As a health educator recently said to me, "if you are going to change the direction of a moving baseball you must give it a direct hit."

Recently in his column Sydney Harris gave an illustration of the "crux of mankind's failure." He reported a story told by a sociologist. Three umpires were discussing the problems of their occupation. One said: "some are balls and some are strikes and I call them as they are." The second said: "I see them coming across and some are balls and some are strikes and I call them as I see them."

But the third umpire said: "I see them coming across and some are balls and some are strikes, but they're nothing until I call them!"

The third umpire was the only realistic one of the three. What is called

a "strike" or a "ball" depends not on the absolute "truth" of each pitch, but on the decision of the umpire. In a real sense, each pitch is "nothing" until the umpire calls it.

Obviously, of course, if his decisions are too often at variance with the judgement of the players and the spectators he will not remain an umpire very long, but except for such rare cases he "makes" balls and strikes out of pitches.

The attitude of the third umpire has an importance far beyond that of baseball or any other sport. It lies in his candid recognition that objective "truth" or perfect accuracy or absolute rightness are impossible to achieve in many human relations.

This is the whole idea behind the establishment of an umpire or a referee or a judge. Within the rules of the game—whether the "game" is baseball or a lawsuit—the umpire or referee or judge makes the decision that both sides are bound to respect, even though one side or the other may disagree with an individual decision.

It would be impossible to run a community of any kind without giving someone power to exercise this function. Not a town, or state, or nation

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could run for one day unless we agreed to accept such decisions, **even when they go against us.**

There are some "rules" of the game in public health that need revision—and I've been assured that these studies are going on. But your help is mandatory in getting the right ones.

In fairness to the public health worker particularly in local situations the confrontations of new programs is staggering. Time does not permit a review of these individually. But some deserve special mention. Our forgotten group may be called the preschool group. The tremendous expenditures in education may be wasted if more help is not given to the mothers of these children in giving them the stimulation and attitudes they need before entering school. The public health worker has the most intimate relation with this group and could best give help to the mother to provide this for her child. Because of lack of personnel she can offer this service only to a few.

And in this area alone genetic counselling and family planning could occupy many times the public health workers we now have.

Most rural areas rarely see a public health engineer yet soon in North Carolina there will be opening an environmental health complex of national importance.

Recently all of us watched Gemini V launched into space. Everything proceeded according to plan and the astronauts received great acclaim. But the television screen did not show the millions of workers who made this flight possible.

Sometimes I think we as local health workers are like this. Everyone knows of Louis Pasteur's work and that we no longer have rabies and many other contagious illness. Millions of the public health workers who really adminis-

tered immunizations and taught sanitation practices are unknown.

For every idea and plan that is launched in public health there must be many public health workers to carry it out. Until this worker is recognized and rewarded properly the work will not be done and people will not benefit from the discoveries scientists are making daily. Studies are needed to identify these workers who are producing and pay them properly.

We are bonded together in our organization that we can make as strong as we wish. It is through such an organization as this that standards we have been talking about and the "comradie" needed can stimulate us to live up to these ideals. Your former president, Martin Hines, has given you some of these on his report from the growth committee. He has said we need an executive secretary or someone who can maintain a central office who can think constantly of our needs and give to outsiders more of our identity. To do this we need to be financially solvent. He has said the answer would seem to be a strong, active, awake public health association that can speak effectively on all matters affecting the public health.

By assuming individual responsibility in knowledge and wisdom, work and labor, loyalty and integrity, trust, kindness and care in working together and in abiding by the rules and with God's help I believe we can best progress toward accomplishment.

**Represent your department well—
you may be the only Public Health
Worker someone ever knows.**

Aphasia — loss of ability to communicate — is a deeply disturbing experience for the stroke patient, as well as for his family, the North Carolina Heart Association points out. For a free copy of **Aphasia and the Family**, write HEART, Chapel Hill, N. C.

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DATES AND EVENTS

- Jan. 25 — Tuberculosis Seminar, Kerr School, Clinton.
- Jan. 26-28 — Annual Program Institute for N. C. Conference of Tuberculosis Workers, Mid-Pines Hotel, Southern Pines.
- Feb. 9-11 — American Academy of Occupational Medicine, Philadelphia, Pa.
- Mar. 3-4 — N. C. Mental Health Association, Annual Meeting, Queen Charlotte Hotel, Charlotte.
- Mar. 3-5 — United Cerebral Palsy Association, New York, N. Y.
- April 21-22 — N. C. Tuberculosis Association Annual Meeting, Grove Park Inn, Asheville.
- May 1-7 — Mental Health Week.

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SWEARING IN CEREMONY

Dr. Jacob Koomen, Jr., will be sworn in as Acting State Health Director at high noon, January 4, 1966, in the John H. Hamilton Auditorium of the Laboratory Building of the State Board of Health.

COVER

Cover painting by Norman Rockwell, courtesy Hallmark Cards, Inc. In a conversation the Editor had with Mr. Rockwell himself, he expressed his interest and pleasure that this picture was to be used by THE HEALTH BULLETIN.



